Communication challenges in maintaining professional behaviour

Introduction

Professional practice involves therapeutic relationships between midwives, mothers, and all the professionals responsible for the mothers’ care; every midwife therefore must be aware of the appropriate way to communicate with all concerned, including her colleagues and students. The language that is used should reflect the recipient’s familiarity with it. This chapter explores the professional expectations of midwives, and the part communication plays in maintaining appropriate behaviour in executing their role and responsibilities as required by the Nursing and Midwifery Council (NMC 2008). Appropriate communication skills take into account when to inform, suggest, act, and most importantly when to withdraw, and remove oneself. Raynor and England (2010) recognize this, noting that although not easy, it is sometimes better to be quiet, non-directive, and wait in anticipation. The practitioner requires confidence in the woman’s decision-making abilities to allow her the freedom to make her own decisions rather than attempting to solve her problems for her. The midwife must maintain a professional friendliness but with a clear boundary at all times. This chapter addresses the contribution record-keeping makes to the quality of care women receive, how the midwife’s behaviour and the way she conducts herself reflect her professionalism, and how students model themselves on the midwives they work with. To be a woman’s advocate, mutual understanding of each other’s position and role is important; some of the legal issues pertaining to the midwife’s role will be discussed. Reflective questions and vignettes are included in the chapter to aid the integration of theory with practice and encourage critical thinking.
Chapter aims

- To reflect on the role and responsibilities of the midwife as a professional.
- To encourage reflection on own record-keeping and devise ways to enhance competency.
- To emphasize how the quality of oral reporting can enhance the provision of seamless care.
- To explore how humour can be used to diffuse difficult situations making necessary interaction more acceptable.
- To discuss when it is appropriate to use self-disclosure to enhance therapeutic relationships.
- To highlight the part role modelling plays in professional socialization.

The professional midwife

The practice of midwives has been closely supervised since the Midwives Act of 1902, making midwives accountable not only for their clinical skills but also their behaviour. Heagerty’s (1996) discussion of the emphasis placed on the moral and social attributes of midwives in the early days is a reminder of the importance of midwives’ professional behaviour.

Students learn their professional responsibilities from their mentors and other midwives they interact with and assimilate information subconsciously in the same way that midwives transmit information unintentionally. It is important for all practitioners to be mindful of the way these messages are transmitted to ensure the desired effect (NMC 2008). As a professional group, midwives share certain values and beliefs that are the glue that binds them together and distinguish them from other professions. Conforming to this professional identity is a sign of commitment to the rules and standards of the profession. New group members (i.e. student midwives) learn the profession’s values and beliefs by early socialization in practice, which is enhanced by effective communication (Raynor and England 2010). They learn through formal teaching in clinical and educational settings and observe qualified midwives in practice settings, where they internalize their practices and attitudes. Pill et al. (2004) highlight the difficulty in defining the word ‘profession’. What is clear from the debate is the part attitude and specialism play, in that the professional demonstrates certain personal qualities that go beyond knowledge and skill. To be an effective practitioner, the possible conflict between one’s own values and beliefs and the professional requirements must be acknowledged and addressed. One of the responsibilities of the gatekeeper of the profession, the NMC, is to ensure that all midwives abide by the codes that are in place to maintain the required standards.

Autonomy

One of the privileges of professionals is the freedom to take responsibility for their own decisions and actions, making them autonomous. With this comes responsibility and accountability for their own practice and personal development, a willingness to admit when in doubt and to seek advice and assistance from colleagues to ensure public safety (DH 1999), and respect for the autonomy of others. Midwives need to feel empowered themselves to be able to offer power to women; however, they may feel restricted having to work within the constraints of
their Professional Code and employers’ policies and procedures. Although in principle both midwives and mothers have the right to autonomy, there is inequality in favour of the professional who has more knowledge. Midwives’ professional standing gives them the power to withhold or provide the information required to empower women to make relevant decisions. Power-sharing with appropriate explanation in an environment where the mother feels able to question the midwife’s views and decisions (Banks 2006; Bungay and Sandys 2008) is a sign of a confident practitioner. This should include an explanation of the rationale for decisions made on their behalf taking into account their health, obstetric, personal, and social needs. When a woman’s wants conflict with the safety and wellbeing of herself and her baby, the midwife must ensure that the woman understands the consequences of her choice so that she is able to make an informed balance between rights and risks. Knowles et al. (2005) argue that adult learners’ self-concept (as in new mothers) reflects the need to be responsible for their own decisions about their own lives. This makes them develop a deep psychological need to be seen and treated by others as being capable of self-direction.

Although information may empower people to make choices, Leap (2010) notes that power is not given but taken, and therefore no amount of information can enable a woman to make the right choice – making a woman’s ability and willingness to embrace power dependent on her relationship with the midwife. Empowerment may not always be an entirely positive experience for less confident women, who may find the stress related to choice and responsibility difficult to cope with and thus desire the support of more authoritative individuals.

**Quality written records and care plans**

Keeping accurate records is an integral part of the midwife’s role (NMC 2008), which reflects the quality of care she provides. Written records should be factual and not based on assumption. Records are more likely to be accurate when done contemporaneously (Solon 2009), as passage of time is likely to affect memory and therefore accuracy. Acknowledging that it is not always possible to record events as they happen, the NMC requires that this be done ‘as soon as possible after the event has occurred’ (NMC 2008: 8). While it is possible for antenatal examination to be recorded contemporaneously, recording the management of a collapsed woman can only be done after the incident has been brought under control and her safety and wellbeing assured. Written records are for the benefit of the women as well as the carers and are used to communicate with other colleagues about the care given, including medication and treatment, the women’s progress, and to give instruction about future care and management to ensure seamless care to both women and babies. They also serve as teaching tools and data for research and audit. Records and care plans should be such that the reader is left with no doubt about the writer’s intent, leaving no room for misunderstanding or error. In instances when it would be unwise or unsafe to record certain information (e.g. issues of domestic abuse) in a woman’s hand-held notes, a written record that is accessible only to relevant staff must be kept.

Although a midwife may have no difficulty reading her own notes, other practitioners may have difficulty interpreting them, which may affect the quality and appropriateness of the woman’s treatment. Yearley et al. (2008) cited illegible handwriting and use of abbreviations and omission of information as examples of the high incidence of poor record-keeping among midwives. This they warn may lead to disciplinary action by the employer or possible civil action by a claimant. The possibility of a midwife’s records being used in court prompts Andrews (2009) to suggest that preparation for a court case begins when a midwife gets ready to make an entry in a woman’s notes. It is in the midwife’s interest to have faultless written communication, as this may be her only evidence to support her practice should allegations be made against her in the future, especially if the passage of time makes recall of the event difficult.
or impossible. As maternity records have to be retained for twenty-five years in case an investigation is necessary under The Congenital Disabilities (Civil Liability) Act 1976, one cannot afford to rely on memory.

It is not only the information given in the records that is important, the language used should be clear and non-discriminatory, and only information relevant to the client’s care needs to be recorded. The relevance of the information must be ascertained before it is recorded and whatever is recorded must be agreeable to the woman and not come as a surprise when it is revealed, as she is entitled to access her own records (DH 2004). As it is not necessary to know that she lives in local authority housing or that she is the grand-daughter of one of the Great Train Robbers or the niece of the Chief Executive of the Trust, this information should not be included in her records. The records are not the property of the midwife and must not be regarded as such. At any time, the records can be scrutinized by relevant personnel, including the employer, the Supervisor of Midwives, members of the Judiciary, and even the Secretary of State (NMC 2007).

Properties of a good written record

- If possible, a written record should be made at the time of the event, or otherwise as soon as possible after. If there is a delay in recording the event, a valid reason must be given.
- Black ink must be used so that it is possible to photocopy the document if necessary.
- Writing should be legible; if script handwriting is difficult to read, the information should be printed.
- Date and time (using the twenty-four hour clock for clarity) must be clearly stated.
- It should be factual and accurate without embellishment or speculation. The writer’s opinion or assumptions should not be recorded, only what actually happened or was said. No offensive remark should be included, and no information omitted.
- Jargon and ambiguous abbreviations are not to be used.
- Records must be signed and name printed if signature is not easy to decipher.
- If it is necessary to make alterations after the original entry, it should be dated, timed, and signed with a single line across the initial word/statement so that it can still be read.

Importance of reliable documentation

- Good communication. Sharing correct information with other caregivers enhances the quality of care, avoids omission and unnecessary (and possible dangerous) duplication, especially of drugs.
- Continuity of care. This allows for seamless care to be provided with efficient use of time and resources. It helps in the planning of future care.
- High standards of care. Changes (improvement or deterioration) can be easily identified and necessary steps taken without delay.
- Legal requirement. In cases of litigation, accurate written records are invaluable.
- Professional requirement. The NMC requires all practitioners to keep accurate contemporaneous records.
- Auditing. Reliable records are required for auditing and for local and national statistics.

Reflective activity 1.1

You are on night duty on the antenatal ward. Sarian is transferred from the delivery suite where she was admitted with a history of possible early labour. What information will you record in her notes?
Feedback

Did your record include the following?

- Date and time of admission to your ward.
- Condition of mother (observations made by you) on admission.
- Condition of the fetus (following abdominal examination you undertook) on admission.
- Any contractions noted, including strength and frequency.
- Any change in the condition of the mother and/or fetus.
- Any medication given.
- The woman’s emotional/psychological state.
- Sleep pattern throughout the night.
- Any food or drink consumed by the woman.
- Condition of mother and fetus at the end of your shift.

Not only will the staff you are handing over Sarian’s care to need to know of any change since admission, they require enough information to plan her subsequent care. A decision will have to be made as to whether she can be safely sent home or transferred back to the delivery suite, and if operative measures are required, knowledge of her stomach contents would be important. The information you communicate to the others caring for Sarian will give a clear picture of her wellbeing and facilitate continuity of care.

Reflective activity 1.2

- Knowing that women have the right to access their records, how does this affect the way you make written records?
- What effect do you think access to records have on the effectiveness of written records?

Handover, verbal descriptions, and stereotyping

Handing over information to other carers is an important part of the midwife's day, when the exchange of accurate information will ensure continuity and high-quality care. It is imperative that enough time is given to this procedure, as an efficient handover is as important as the care the woman receives. It should also be done in an environment that is free from distractions such as ringing telephones so that one’s full attention can be devoted to the exercise. The report must be complete and unambiguous leaving no room for misinterpretation that might compromise the care and possible safety of women and babies. The importance of verbal handover should not be compromised because written records are available, as it may be impractical to access them if there is an emergency or if the ward is busy, thus emphasizing the importance of accurate handover to enable the midwife to make a quick judgement about prioritizing her care. For example, a midwife caring for postnatal women reports at handover of an anxious mother who might give up breastfeeding because her baby has difficulty latching on to her breast. In the same ward, a new mother would like to be shown how to bathe her baby. Relevant information about the emotional state of the breastfeeding mother will help the midwife to prioritize her care, realizing the importance of assisting the mother with breastfeeding and giving the mother waiting for a bath demonstration some idea of when she would be free to assist her.

On a routine antenatal visit, a community midwife notes that a woman booked for home birth is having lower backache and vague abdominal discomfort. Reporting this to the on-call midwife will assist her in planning a possible call out.
A woman who is unfamiliar with the culture of the hospital or is not confident about looking after herself or her new baby needs education and support, not sarcasm or abuse. To refer to her at handover as ‘stupid’, ‘thick’, or ‘clueless’ is depriving her of the respect she deserves (NMC 2008) and likely to give those who will be caring for her a negative impression of her. Practitioners have a responsibility to behave professionally to everyone they interact with; this includes mothers, their relatives, colleagues, and students. Whether or not women are present at handover, they must be described in a respectful manner.

Case vignette 1.1

Andrea, an adolescent mother, is in early labour supported by her boyfriend David. Andrea is rather vocal and uncooperative, shouting at David who retaliates in like manner. Attempts to calm her down are met with strong language, blaming David for the pain she is experiencing, and demanding epidural analgesia. Andrea’s manner may be her attempt to disguise her true feelings. She could be terrified of the pain and unfamiliar experience and maybe believes that staff members disapprove of her, a school girl, having a baby. This may be the only way she knows of masking her embarrassment. She needs assurance that she is not being judged and that the care on offer is unconditional. At change of shift, consider the verbal report of the midwife who is handing over Andrea’s care. Handing over could take the following form.

**Midwife 1:** (addressing Andrea) Andrea, this is Susan. I have come to the end of my shift and she is taking over from me and will be looking after you from now. (addressing midwife 2) This is David (turning to David), Andrea’s partner.

**Midwife 2:** (smiling) Hello Andrea, hello David.

**Midwife 1:** (handing over to midwife 2) Andrea is a primadravida. (addressing Andrea) That means you are having your first baby. (addressing midwife 2) She is due today and was admitted two hours ago in early labour. Her contractions are irregular and weak, she is complaining of a lot of pain and requests an epidural. Although she was not too keen on having a vaginal examination, she agreed to one and her cervix was found to be one centimetre dilated. I have explained to her that it is too early to have an epidural and suggested that she walk around the unit with David to encourage more regular and stronger contractions but she would rather stay in bed.

The handover is factual and respectful, introducing the midwife to both Andrea and David so they are aware of the changeover. The midwife did not attempt to interpret Andrea’s behaviour or convey her feelings about it to the midwife who is taking over her care. No stereotypes were used relating to her age or marital status that would confirm her feeling of being judged. The midwife did not minimize her account of the pain but reported her suggestion of how she could manage it. Andrea’s altercations with David had no effect on her care or wellbeing so was not regarded necessary to report it to midwife Susan. Only the information relevant to continue Andrea’s care was given.

Oral reporting and pronunciation of clinical words

Practitioners do not always appreciate the miscommunication that can occur when working with either a junior midwifery student or students or practitioners from other disciplines who may be on placement in midwifery settings. Oral reporting is an important part of the learning
process and therefore needs to be at a level that everyone can understand. The speed and tone of one’s voice, especially when using unfamiliar words and expressions, can lead to misunderstanding and failed communication, as commonly used words in midwifery may have a different meaning in another setting. The recipient may not feel confident to ask for clarification and the responsibility to ensure comprehension lies with the practitioner who is giving the report. The mentor of a new student may either bring to the attention of the reporter the needs of the student or make it her duty to explain the unfamiliar terminology to her later.

Using abbreviations during handover such as EDD (expected date of delivery), SROM (spontaneous rupture of membranes), RDS (respiratory distress syndrome), and CTG (cardiotocograph) may not be familiar to the novice. Even if abbreviations are avoided, terminology familiar to the midwife such as grunting and spontaneous rupture of membranes may be meaningless to a new student unless they are explained to her. Also, the pronunciation of certain words, such as ‘lochia’, is different from its spelling. This needs to be highlighted so that the student can write it down for future reference.

If students do not understand the language being used, they will not gain the potential learning experience that handover can provide. They may be reluctant to ask for clarification because everyone else appears to understand and they do not wish to be regarded as unintelligent. It must not be assumed that students who have been employed elsewhere in the NHS will be familiar with midwifery terminology; even if they have heard some of the words before, they may not know their meaning or spelling.

**Reflective activity 1.3**

Try to think of six words or phrases used in midwifery the meaning of which you did not understand the first time you heard them, particularly at handover.

- How did you feel at the time?
- How did you find out the meaning and spelling of these words?

**Use of humour**

Humour is often used to create a relaxed and less stressful atmosphere in the presence of uncomfortable feelings and emotions such as tension, fear, or embarrassment. Humour may be used for the benefit of the person using it or for others, but whatever the reason for its use it should not be at the expense of others, especially in professional settings. Humour used by practitioners should have no sexual connotations and there should be no telling of jokes that are considered professionally inappropriate. A practitioner may use humour to conceal her embarrassment when she realizes that she has made an error, for example pronouncing the woman’s name incorrectly. This gives permission to onlookers, either colleagues or mothers, to acknowledge the mistake and her ability to correct it. She is more likely to gain trust and approval than if she attempts to conceal or ignore the mistake, as acknowledging the mistake makes it easier for students and other junior staff members to acknowledge and learn from their own mistakes. While humour can enhance communication, if used to cause embarrassment to others, especially the less confident student who is unfamiliar with the practice area, it could be destructive. Tappen et al. (2004) caution the use of humour, as its individual nature makes anticipating its effect difficult. Laughing with – rather than laughing at – the subject and the appropriateness of
such humour will make the difference between therapeutic and destructive humour. A colleague often uses humour successfully when teaching to emphasize issues that students find difficult to understand, which requires confidence and good communication skills to achieve the desired effect.

O’Toole (2008) suggests that the use of humour will have the desired outcome if a good relationship exists between the people involved. To avoid misunderstanding and misinterpretation, therefore, use of humour should be avoided in an environment where the culture is not understood. It must be remembered that while midwives are familiar with the maternity environment, some women and new students may be uncomfortable or even frightened by it and may find inappropriate humour unhelpful.

Some women find it difficult to give intimate information about themselves or to undergo intimate examinations; to allay anxiety or reduce embarrassment of the woman, appropriate humour can be used to defuse the tension and stimulate conversation. The midwife may say something like, ‘Don’t you think men are lucky they don’t have to go through this birthing process?’ Or, ‘How do you think men would cope if they had to take turns in giving birth?’ This might create a more relaxed atmosphere giving the woman a chance to get involved in discussion with the midwife.

A woman might use humour to conceal her concern or anxieties about issues that she would like addressed but finds difficult to talk about. She may refer to her oedematous legs as ‘balloons’ while being concerned about the size of them but not wanting to appear so, not knowing what the midwife’s reaction will be. The midwife should take the opportunity to discuss it with the woman and give her the appropriate advice. A new mother may be uncertain about the possible length of her lochia. Being used to having light menstrual flow, she may be confused and concerned that having just had a baby she is having to change her sanitary towels rather frequently. She may joke about it to conceal her anxiety with the hope that the midwife will address the issue. She may say something like, ‘If this continues, the shop will run out of sanitary towels, or, I will soon run out of blood’. This is an opportunity for the midwife to explain about the nature and possible length of her lochia and any other anxieties she may have. The midwife needs to know when it is appropriate to use humour and how to respond to women who use humour to disguise their embarrassment or discomfort.

**Inappropriate self-disclosure**

Self-disclosure involves the sharing of personal information with others; this may be intentional or unintentional and done in a variety of ways in professional and non-professional settings. While acknowledging the advantages, van Servellen (2009) highlights the negative impact of self-disclosure if used inappropriately, thus the appropriateness of any disclosure should be weighed up against the benefit to the woman. This requires the midwife to be mindful of the timing and content of any disclosure that she may make to ensure that it is in the interest of the receiver, whether it is the woman she is caring for, a student she supervises or a colleague she interacts with. The disclosure may reveal the midwife’s values (‘I believe termination of pregnancy is wrong’), attitudes (‘I get cross when women keep asking for epidural’), feelings (‘I like being a mentor’), or experiences (‘This is the first time I have cared for a woman with placenta praevia’), which may enhance or inhibit therapeutic relationships.

Midwives enjoy a unique and privileged relationship with women built on honesty, trust, and respect. It is a friendly relationship with boundaries that must be maintained for the benefit of all concerned. Students may find it difficult to appreciate which information is appropriate or inappropriate to share with the women they care for, and the importance of timing such disclosure. Professionals often share their personal experiences with other colleagues or the women
they are caring for to demonstrate empathy, especially when they are experiencing difficulties. A mentor may disclose to her student who has difficulty identifying the fetal position on abdominal examination, that she had the same difficulty as a student. Though the student may appreciate the empathy, she knows she has to master that skill, so in addition to the disclosure, she needs support to help her achieve it. The mentor will then go on to give her useful tips to aid her skill. The disclosure is deliberate with the intention of helping to reduce the student’s anxiety and boost her confidence.

Appropriate disclosure can be helpful when shyness or unfamiliarity may inhibit communication, such as in the case of a primigravida’s initial labour ward experience. The midwife may disclose how apprehensive she was when she was in labour. A midwife caring for a woman whose baby has Down’s syndrome may feel it appropriate to disclose that she has a child with the same condition. This feeling of solidarity may encourage the woman to express her feelings and communicate in a way she may have otherwise found difficult, making it possible for the midwife to direct her to the appropriate support. However, the midwife must be careful not to shift the focus away from the woman to herself, satisfying her own needs rather than those of the woman (O’Toole 2008). While Sully and Dallas (2010) believe that self-disclosure is an important part of human relationships, they also advocate careful consideration of the boundaries surrounding it; self-disclosure that enhances communication and provides comfort for the woman cannot be a bad thing provided the midwife maintains her professional stance. A midwife who discloses her uncertainty and negative emotions will not help an anxious woman. In contrast, a midwife who discloses her sadness by crying with the mother who has just lost her baby displays her humanity, which can be comforting and therapeutic for the mother. It must be remembered that unlike many Western cultures where self-disclosure is acceptable, in some African cultures self-disclosure is restricted to very close family members and so women from this background may be reluctant to disclose – or expect strangers (as professionals would be to them) to disclose – certain information or emotions.

Some disclosures may be appropriate if made to another professional, whereas it might cause anxiety for a woman who already feels uncomfortable with the environment or procedure. While it may be appropriate for a student midwife performing a vaginal examination for the first time to disclose embarrassment and or incompetence to her mentor, it may increase the embarrassment and feeling of anxiety of the mother who has never experienced this procedure before. To help build the confidence of an adolescent mother, a midwife may disclose to her that she had a baby when she was about her age and that she pledges her support. In contrast, for the midwife to disclose to a mother who is having difficulty with breastfeeding her baby that she had no difficulty feeding any of her own three children is irresponsible and unhelpful, as the focus is on her experience rather than the young mother’s needs.

The woman or her companion may disclose information that is relevant, such as abuse or violence towards the woman or a child, which has to be acted upon. An inappropriate disclosure, however, about her or her husband’s infidelity or unusual sexual habits should not be encouraged. The midwife’s body language as well as her verbal communication will demonstrate either unconditional positive regard, or make it clear that the disclosure is unhelpful and not welcome.

Case vignette 1.2

Jody, who is expecting her first baby, developed a good rapport with her midwife at the booking visit. She called in to see her at the health centre and asks her advice before making a decision about screening for Down’s syndrome. She does not know that the midwife had been in a similar position.
Maintaining professional behaviour

Being a role model

Students become socialized into the profession by modelling themselves on midwives who communicate their professional values, sometimes unintentionally, through non-verbal messages. A good role model is someone with a positive attitude that others respect and wish to emulate. We can all recall at least one person in our professional life that fits this description; it may have been our first mentor or someone else we worked alongside. What is learnt in the classroom is reinforced by what is experienced in practice and becomes embedded in the subconscious. Practitioners reinforce their professional values by emulating experienced professionals; even post registration, we may work with colleagues that we admire and wish to emulate because of their professional knowledge and skills, or because of their good interpersonal skills. Our desire to emulate those we respect, according to Davis et al. (2006), will have a lasting effect if a positive relationship exists. Raynor and England (2010) share this view and agree that students gain the required competencies and learn their professional roles and comportment by modelling what they are exposed to in the learning environment. They also emphasize the impact of midwives’ communication skills on the students that emulate them, and warn that this can create a lasting memory that will determine the students’ future practice. Every practitioner is a role model (either a good or a bad one), and as students internalize what they observe in practice, this places a moral responsibility on the midwife, since her behaviour – good or bad – is likely to be replicated and perpetuated.

Students learn how to communicate with women by observing and listening to their mentors. It may surprise and serve as a reminder to practitioners the extent to which students imitate midwives when they overhear them communicate with women, using almost identical vocabulary to their own. If there is inconsistency in the midwife’s behaviour and practice, confusion ensues and the modelling becomes negative. Change of behaviour and attitude is learned and reinforced by consistent example; therefore, a midwife who advises a mother always to wash her hands after changing the baby’s nappy and does not do so herself will not be taken seriously. Midwives must be aware that their values and beliefs are reflected in their behaviour and internalized by others, and that students will adopt their mentors’ behaviour when faced with similar situations they experience while shadowing them. A midwife who believes in...
woman-centred care will demonstrate this by giving women all relevant information to enable them to make choices relevant to their needs. By being authoritative and not listening to women, she demonstrates to students her belief that power and control belong to her, not to the women.

Case vignette 1.3

Mother: (looking worried and calling out to a midwife nearby) Excuse me sister, my baby’s stool is a funny colour, it is not the same as it was yesterday.

Midwife: (in a matter of fact way while walking away) Babies’ stools change all the time, did you not read it in your baby book?

The student may respond in similar manner in future because that is what she observed. In contrast, the midwife may respond in a more sympathetic way.

Midwife: (walking over to the mother and inspecting the nappy) Don’t worry, this is normal, stools change as baby digests the milk. You will notice that the colour of the stool will change again in a couple of days or so to yellow. If you are worried, call one of us to check just to put your mind at rest.

A midwife who speaks abruptly to women or delights in humiliating those she deems to be less powerful sends negative messages to the student, who may believe that such behaviour is acceptable and so behaves in the same way when she is unsupervised, or does it to please the midwife model when working together as she believes it would be in her favour if she copies the midwife’s style.

Legal issues

While providing the best possible care for women and their babies, the midwife must conform to the law of the land in which she practises (NMC 2008). In the United Kingdom, there are a number of laws that impact on the role of the midwife that cannot be given justice to because of the constraints of this chapter. The role of the midwife is enacted in law, making it illegal for anyone not duly qualified to practise as such. European Law stipulates the requirement of the educational programmes undertaken to enable students to become registered midwives, and the minimum activities required of midwives (NMC 2004).

Consent

The NMC (2008) clearly states the midwife’s responsibilities for obtaining consent from the women she cares for. In most cases, maternity women are capable of giving or withholding consent as the case may be. Whether the consent is written or verbal it must be informed, making it the responsibility of the midwife to give the woman all the necessary information in a format that she clearly understands, without exerting any pressure. Even if the midwife feels it is in the interest of the woman, the woman may choose to decline any treatment she does not understand or feels is irrelevant. The midwife may need to perform a vaginal examination to inform her management of the woman’s labour; however, if this is done without the woman’s consent, this is classed as ‘battery’ (Dimond 2006). It is the midwife’s responsibility to
effectively communicate the importance of this procedure to the woman so that she is clear about the advantages and disadvantages and is able to decide whether to provide her consent. The midwife’s sound knowledge is necessary if she is to give the woman full and accurate information. In situations where the consent is verbal, a written record should be made of the fact that informed consent was obtained.

Reflective activity 1.4

Ade’s first baby, Femi, was born six days ago. You are making a postnatal visit and realize that Femi is due for a neonatal blood spot screening test. What communication skills would you use to gain consent from Ade to obtain the sample?

You will be inflicting pain on Femi who is most likely to cry, which might upset his mother. Be honest and open about this. Listen to any concerns or anxieties Ade may have. You need to provide her with all the relevant information to assist her in making an informed choice about giving her consent without pressure. You need to acknowledge her anxiety, showing empathy and care and demonstrating unconditional positive regard should she decide not to give her consent or asks for more time to consider the test.

Checklist

- Do you have correct information about the test and feel confident obtaining the specimen?
- Ascertain that Ade has already been given the relevant information; if not, explain the test to her. Reinforce the information she already has; correct any misinformation or misconception if necessary. Be prepared to answer questions.
- Have a professionally friendly attitude that is genuine and caring.
- Explain to her that the baby’s crying will be short-lived and that a feed may be needed to pacify her.
- Explain to her that you need her consent to perform the test and that the decision is hers.
- Let her know that she will be informed of the result of the test.

Confidentiality

Women may share privileged information with midwives that they probably have not shared with any one else before, maybe not even their partners. Women need to be assured that this trust placed in midwives is maintained always and that when it is necessary for their wellbeing to share information with other relevant personnel, their permission will be obtained. The same degree of diligence is required whether the information is verbal or in written form, or obtained on physical examination. Acknowledging their responsibility regarding confidentiality, students must take care not to share information about colleagues or women in their care with a third party without good reason. Confidentiality may be breached unintentionally unless the student is diligent about her communication with others. A relative who appears concerned about a woman or a baby may cleverly question a student or initiate a conversation with her in a way that the student may inadvertently divulge information that is meant to be confidential. A student may unintentionally breach confidentiality if the midwife supervising her learning in practice fails to make the confidential nature of the information clear to her as highlighted in the following vignette.
Communication Skills for Midwives

Sometimes, students are not entrusted with sensitive information because of the midwife’s attempt to respect the woman’s confidentiality and maintain her trust. However, if the student is caring for the woman, she needs all relevant information to enable her to meet her physical, emotional, social, and spiritual needs. The midwife needs to make a judgement about who needs what information, making the confidential nature of it very clear, as withholding relevant information from those involved in delivering care can have unwelcome consequences.

If the student had been given relevant information about Mina’s wish, she would not have initiated the conversation with Liam. Disclosing it the way she did is likely to cause distress to Liam and disturbance within the family. Mina’s confidentiality has been breached, albeit unintentionally and without malice.

Case vignette 1.4

Liam’s wife Mina recently gave birth to Joy, her second baby. Before Mina met Liam, her first pregnancy was terminated at ten weeks for social reasons followed by the birth of a son Tom, who was given up for adoption. Mina confided in her midwife that Liam is unaware of her past obstetric history and that he believes that Joy is her first child. Mina was in the bathroom when a student undertaking an unsupervised visit arrived at their home for a postnatal visit. She got engaged in conversation with Liam.

Student: Is your family complete now or will you try for another?
Liam: Oh no, this is our first child, I would like to have a boy next, then maybe we will call it a day. I would like someone to play football with (smiling).
Student: What about your six-year-old son, does he not like football?
Liam: Six-year-old son? We don’t have a son, this is our first child.
Student: Oh! (looking surprised and flicking through her notes) Your wife is Mina Kay, your address 6 Eaton Close?
Liam: That’s right.
Student: (looking at the notes and muttering) Para two plus one (looking rather puzzled).
Liam: What is this two plus one?
Student: (looking embarrassed) I am sorry, there must be a mistake in the records, they have Mina down as having had a termination and a son. They must have got the wrong Mrs Kay. I will correct it when I get back to the Health Centre.

Sometimes, students are not entrusted with sensitive information because of the midwife’s attempt to respect the woman’s confidentiality and maintain her trust. However, if the student is caring for the woman, she needs all relevant information to enable her to meet her physical, emotional, social, and spiritual needs. The midwife needs to make a judgement about who needs what information, making the confidential nature of it very clear, as withholding relevant information from those involved in delivering care can have unwelcome consequences.

If the student had been given relevant information about Mina’s wish, she would not have initiated the conversation with Liam. Disclosing it the way she did is likely to cause distress to Liam and disturbance within the family. Mina’s confidentiality has been breached, albeit unintentionally and without malice.

Reflective activity 1.5

You have been looking after Jane and her baby for the past three days. Your mentor, Kim, is on her tea break when you answer the telephone. A female enquirer who claims to be Jane’s sister requests information about Jane and the baby. How would you respond?

Points to consider
- How do you ascertain she is who she says she is?
- Do you know what information Jane wants to share with others, particularly her sister?
- Is the information that you are giving correct and relevant?
- Is your mentor aware of your communication with the caller and with Jane?
You need to ask for the caller’s full name and where she is calling from, as Jane would need this information to ascertain that it is her sister and decide what information she wants to share with her. No information should be given to anyone without Jane’s consent, and it is she who decides how much information to share with any individual. As Kim is responsible for Jane’s care, you must inform her about your communication with the caller and Jane.

**Reflective activity 1.6**

Consider a very personal piece of information you have shared with someone you trust. Having stressed the need for confidentiality, you discover that this information has been divulged. How would this make you feel? What effect would this have on your relationship with this person and others that you have a similar relationship with? What would be your reaction to sharing sensitive information with anyone in the future?

If the scenario were reversed with you as the mother’s confidante, how would you feel your relationship would be affected if you broke her confidence whether for a valid reason or unintentionally?

**Conclusion**

The midwife’s acceptance into the profession binds her to the rules and regulations and she must practise within the boundaries set by her professional body and the country in which she practises. ‘Being with woman’ requires her to work for the benefit of the women she cares for and not her own benefit. If her personal values and beliefs conflict with those of the profession, she needs to address them before she can commit herself fully to her role and responsibilities. Bearing in mind that the records she keeps are permanent, she must take care to ensure that they are accurate and can withstand scrutiny for professional or legal reasons. All women regardless of their status in life, including students and other colleagues, deserve to be treated with respect and any humour used should be for the benefit and not at the expense of others. Midwives must be mindful that their attitude, behaviour, and practice are observed and copied by their juniors, and so must endeavour to be good role models always. No matter how well-intentioned midwives are, women’s consent must be obtained before performing any procedure or sharing information about them or their babies.

**Summary of key points**

- The quality of written and oral records reflects the quality of care given by the midwife.
- Humour can be used in the right context to diffuse an uncomfortable situation, relieve tension, and stimulate discussion. It should never be used to cause embarrassment or offence.
- Midwives must practise within the legal boundaries of the profession.
- Self-disclosure should only be used if it is in the woman’s interest.
- Midwives must bear in mind that they are role models to students and the mothers they care for.
References


Useful websites

www.dh.gov.uk (Department of Health website for Green and White Papers)

www.nmc-uk.org (Nursing and Midwifery Council website)