

## **ABSTRACT**

Professional dilemmas within practice have been linked to facing a choice, whereby the midwife is presented with two alternative options neither of which is right or wrong thus leaving the midwife facing a crossroad leading to a professional dilemma.

As a third-year case loading student midwife, I encountered a professional dilemma during an intrapartum placement whilst working on a busy obstetric unit; to use vaginal examination (VE) to confirm full dilatation, therefore, pertaining to a medical approach, or advocate normality and 'with woman' approach. This article explores the three influential forces which contributed to creating the dilemma; influential culture of obstetric units; the midwife-woman relationship and the importance of assertive behaviours to achieve autonomy. Through reflection and use of Gibbs' reflective cycle (Gibbs, 1988) I highlighted the need to further develop my assertive skills which also led me to make recommendations to my own practice; this helped me transition from student to a newly qualified midwife.

## **Background**

Midwives must be autonomous practitioners; a stipulation of the Nursing and Midwifery Council (NMC, 2018). The dilemma in question presented me with the challenge of conforming to a medicalised approach to care, or uphold my values and philosophies as a student midwife using a non-interventionist approach to achieve autonomy. It was therefore essential for me to consider my skills and attributes as a student midwife, reflecting on and analysing key factors that determined my decision-making in practice when faced with the dilemma of using vaginal examination (VE) to confirm full cervical dilatation, or advocate normality and a woman-centred approach. Throughout this article, I will refer to the woman I cared for as 'Faye'.

I first met Faye when she arrived at the obstetric unit for triage in suspected labour, two nights previous to when the dilemma occurred. I had already begun building a trusting relationship with Faye and she requested my care when admitted to the unit in established labour. Faye had previously experienced a traumatic birth and described feelings of powerlessness and loss of control; Faye hoped the experience of this labour was to be positive and I was aware she trusted me to help achieve this. Faye progressed well during labour and labour was considered low risk. However, I was caring for Faye on a busy obstetric unit whereby the norm was to confirm full cervical dilatation with VE, therefore pertaining to a medical approach. Also, I was working under the supervision of a midwife other than my mentor who was perceived as liking high-risk labours, in contrast to my mentor who advocated normality and 'with woman' approach. Therefore, it could be questioned whether this influenced my behaviour, thus creating the dilemma due to practicing outside my comfort zone and my mentors' trust. Through the process of reflection, I identified three influencing factors namely, the medicalised culture of the unit; maintaining a trusting relationship with the woman and promoting empowerment; and assertive behaviours needed to achieve a 'with woman' approach in a medicalised unit.

### **Influential culture of obstetric units**

In a study by Zhang *et al.* (2015) to identify differing views of midwives working in various birth settings, it was concluded all midwives shared the same philosophies of care; practice should be woman-centred and autonomous. However, the setting in which the midwife worked often contributed to the degree of success of these elements, as the midwives believed it was harder to form a 'with-woman' relationship and woman-centred care in an obstetric unit compared to an MLU. Freeman *et al* (2006) examined how birth environments

affect the care midwives give to women in low-risk labour, and it was found a key aspect commonly discussed was the frequency of VE in obstetric units. Also, it was established midwives felt the common practice of intervention and the need for technology was influenced by the medical approach to care of the obstetric environment, therefore supporting Walsh (2012) who suggests the incidence of intervention to be increased because of this. Moreover, what remained predominant in the midwives practice within this study was maintaining a holistic and individualised approach to care, regardless of the medicalised culture of the unit. It was evident, those midwives who practiced autonomously, without the strict adherence to guidelines were those with more clinical experience, invariably possessing skills and experience which fell absent in my practice during that stage of my training. It would seem medicalised practice is 'deep-rooted' within midwifery and has, therefore, become 'traditional' (Freeman *et al.*, 2006); it was 'traditional' practice which I questioned in this dilemma. Parsons & Griffiths (2007) examined the influence of socialisation upon midwives and the practices and beliefs among them. It was understood, midwives will acquire specific beliefs and knowledge of others within practice, to become accepted within the culture of the unit, therefore, becoming socialised (Chamberlain, 1993). Medicalisation of childbirth has increased, therefore it could be assumed many midwives have been trained and socialised into a medical environment, where routine intervention is common practice (Parsons & Griffiths, 2007). Concernedly, midwives will follow traditions and rituals regardless of evidence-based practice, as over two-thirds of midwives who participated within Parsons & Griffiths (2007) study admittedly followed the culture of practice which is not based on evidence or policy.

Although Parsons & Griffiths (2007) study discussed the dilemma of oral intake during labour, the authors recognised many midwifery practices are based on tradition rather than policy, therefore important to highlight, as it is thought socialisation leads to diminishing autonomous practice and consequential lack of authority to challenge practice. Traditional

midwifery skills are at risk of becoming lost due to an over-reliance on technology (Walsh, 2012), with fear of skills such as intuition and observation considered as nothing more than 'anecdotal evidence' due to their lack of 'scientific evidence' to quantify their use in practice. Within the obstetric unit where the dilemma took place, it was common practice to VE to confirm full cervical dilatation due to the busyness of the unit and heavy workload of each midwife. The ward co-ordinator had to be aware of how each woman was progressing in labour, to prioritise care and alert medical staff when each woman had reached full cervical dilatation; common factors which are used as reasons why midwives should intervene according to Deery & Hunter (2010) and reasons I questioned, whether it was this which created the dilemma as I was aware of such practice, and the reality that most midwives would have performed the procedure. Jefford & Fahy (2015) propose experienced midwives should pay greater importance to intuition over technical brilliance; expressing belief, courage, and trust with more value even though Parsons & Griffiths (2007) suggest socialisation into culture of practice can lead to midwives adopting traditional practices. This is reflected in seminal literature by Benner (2001) in her theory of novice to expert, and believes intuition and experience is an awareness that is integral to learning and development, therefore expertise should be considered as a journey rather than an arrival. Moreover, the ability to maintaining a non-intervention approach during women's labour is dependent upon other learnt skills gained through experience. Therefore, reinforcing 'experience as a journey' and, as suggested by Jefford & Fahy (2015) skills such as 'let women labour' can only be achieved with expertise and competence. My experience of working with a supportive mentor, who championed normal birth gave me increased confidence in 'normality'. However, working with another midwife perceived as liking 'high risk' labour as opposed to 'normality', and who was unfamiliar with my practice subsequently undermined this confidence, which became apparent during this dilemma.

With this in mind, Arundell *et al.* (2018) believe medicalised units often lead to a culture of obedience whereby to achieve survival, practitioners conform to the culture of the environment. Henderson (2008) describes this as students must not 'rock the boat', and Arundell *et al.* (2018) as students need to 'fit in'. I was faced with this dilemma due to pressures of conforming to the culture of practice, and my desire to fulfil Faye's wishes by avoiding unnecessary intervention. It seems midwifery practice can often focus on 'getting the job done' rather than providing individualised women-centred care which I always strive to provide (Kirkham & Deery, 2006; Lipienné *et al.* 2014). This often leads to midwives feeling dissatisfied with their work, which can subsequently lead to ineffective practice, a build of defences and consequent burn out, resulting in midwives reluctantly leaving the profession if such feelings are not learnt from and resolved (Kirkham & Deery, 2006; Lipienné *et al.* 2014). In a study by Hauck *et al* (2007), it was concluded a strong relationship between midwife and woman, which promoted the woman's involvement in the management of her care strengthened feelings of control, and women were more likely to consider their birth experience as positive, regardless of the physical outcome. Also, McCourt & Stevens (2009) identified women valued the information given to them, and found having control over what happened during their labour to be more positive when assessing their childbirth experience, rather than how complex or straightforward their pregnancy and childbirth experience was. Upon reflection, I felt a strong need to advocate for Faye as I had begun building a trusting relationship with her, and she trusted me to help her achieve a positive outcome; a mutual trust which is said to be just as important to the midwife as to the woman (Mccourt & Stevens, 2009). Therefore, I felt reluctant to intervene unnecessarily as I did not want to jeopardise the relationship we had built.

## **The Midwife-Woman Relationship**

A key role and underlining philosophy of midwifery practice are to be 'with woman' (Hunter, 2015). Therefore, building trusting relationships and helping empower women to achieve a positive experience of childbirth, are ultimately the values I uphold in practice and those I wished to maintain when caring for Faye. Hermansson & Martensson (2010) believe women must feel empowered by the midwife in order to strengthen their childbirth experience, and the NMC (2014) state there must be a partnership formed between the midwife and woman; furthermore, this is supported by the International Confederation of Midwives (ICM, 2011) who advocates empowerment of the woman by the midwife.

Hermansson & Martensson (2010) believe empowerment is easier to understand through absence and feelings of powerlessness, dependence, and alienation. If Faye had these feelings within my care, I would have felt I had done her an injustice, indicating I had not created a 'with-woman' relationship. However, Hunter (2015) suggests the process of building relationships happens over time, and although I had only cared for Faye during her current labour and previous admission for triage, it was apparent we had a trusting relationship. Faye was comfortable to discuss her previous birth experience with me, therefore reducing her anxieties which are said to be as a result of a 'with-woman' relationship (Hermansson & Martensson, 2010). An integral part of practice, is to avoid situations that cause maternal stress and instead promote normality; this was particularly important when caring for Faye based on her previous experience. Faye had knowledge of 'normal childbirth' and attended parent craft classes to further support this; I also reinforced 'normality' by discussing positioning in labour and pain relief options if she felt this necessary, to avoid assisted delivery. Therefore, I felt personally responsible to ensure Faye achieved the outcome she wished as she trusted me to facilitate normal labour.

Consequently, if midwives responded to women's experiences, there would be an increased focus on social models of care, leading to improvements of the quality of care offered in maternity services (Better Births, 2017). Furthermore, it could be argued holistic and individualised care models are ideal practice in facilitating a 'woman-centred' approach and the quality of services Better Births (2017) wishes to achieve, however, as previously discussed the environment can be a major factor in preventing this. I believe the strength of the midwife-woman relationship is reflected in the quality of care received; a view supported by Hauck *et al* (2007) in their qualitative study of women's experiences and the importance of feeling informed and involved in decision-making regarding care. Through the exploration of variables, which could potentially impact the childbirth experience of the women in our care, it allows us to consider what is important to women and begin to understand how we can facilitate a relationship which is essential to women, to ensure a positive experience (Hauck *et al*, 2007).

The complexity of the 'with-woman' relationship is explored in a secondary analysis of eight qualitative studies by Lundgren & Berg (2007). It is suggested, women surrender themselves to the midwife during childbirth, however, despite this, women still wished to maintain control but often lose trust in their ability to do so (Lundgren & Berg, 2007). Arguably, this highlights the importance of the midwife-woman relationship, and for the midwife to empower the woman to trust in her ability to labour. Although this analysis highlighted important aspects, it does have its limitations; all studies analysed were qualitative and based within Swedish maternity units, therefore, omitting quantitative research and that from other countries. However, a recommendation of the analysis was midwives need to have a holistic approach to care; to consider each woman as an individual and only intervene when necessary (Lundgren & Berg, 2007). For this reason, as I believed Faye was progressing well in her labour, I felt VE would be unnecessary and not justified therefore, I believe this is why the dilemma presented itself when it did. Faye was showing

external signs of full cervical dilatation as she had a spontaneous rupture of membranes, a change in behaviour, rectal pressure and an urge to push. Also, Faye's previous VE was three hours prior to observation of these signs, where cervical dilatation was confirmed to be eight centimetres.

Through analysing the dilemma, it transpired I did not lack confidence in recognition of external signs for confirmation of full cervical dilatation, yet rather unable to voice my opinion to enable me to advocate normality. I was aware given the same situation, the midwife I was working with would have performed VE to confirm full dilatation and therefore I felt pressurised due to this. Upon exploration of the dilemma, I realised I did not lack skills or confidence in advocating a non-intervention approach, but instead the assertive skills required to express my opinions. I felt I was unable to openly express my feelings directly to the midwife I was working alongside; an expression Ibrahim (2011) considers a trait of assertive behaviour, specifically if it violates the other's personal rights. Moreover, through assertive behaviour comes the ability to make independent decisions, as it is considered a communication process that is vital to practice, not only between midwife and woman but also between colleagues (NMC, 2018). Assertive behaviour is compulsory in midwifery (Timmins & McCabe, 2015) however, there is limited research to inform us of the assertive skills of students, therefore, an area which could benefit from further exploration to aid confidence of students and development in practice (Ibrahim, 2011). It is believed, lack of assertiveness may lead to low self-esteem, therefore unhealthy for the midwife and consequently affecting care provided (Timmins & McCabe, 2015).



## **Expressing assertive behaviours**

It is believed, factors such as anxiety as a result of little confidence, alongside, lack of knowledge, low self-esteem, and concerns over how one is viewed in the light of a colleague in addition to fear of hostility, all contribute to preventing assertive behaviour (Ibrahim, 2011). It was evident, in research by Timmins & McCabe (2015) a common reason for expressing assertive behaviour was the responsibility of the patient, when exploring potential barriers and facilitators within nursing and midwifery; this was similar to the dilemma. An emerging concept from Timmins & McCabe (2015) study was fear of the negative response from colleagues when advocating assertive behaviour; this was apparent within the dilemma as I avoided challenging 'common practice' on the unit, and practice perceived to be favoured by the midwife who I was working with, for fear of negative response. As a result, I performed VE which not only meant I was conforming to the culture of the unit, yet also contradicted my own values and philosophies I regard as central to my practice. A view further supported by Ibrahim (2011) who recognises, hostility in practice can prevent assertiveness, which reinforces Arundell et al. (2018) with additional evidence, to suggest conforming to practice is a regular occurrence within medicalised units. Upon reflection, I regarded my act of VE to be a failure of my care, because I conformed to practice rather than advocate for Faye, despite my wish to empower her by maintaining a non-intervention approach.

## **Reflection**

As reflection is central to practice, I deemed it necessary to explore experiences of newly qualified midwives who, encountered dilemmas similar to my own during their first year following qualification, and in their role of transition to qualification. This enabled me to

analyse how I could further develop my own practice. These experiences were found in an ethnographic study by Hobbs (2012) where, participants were newly qualified midwives who described midwifery culture as one of 'fitting in'. This further supports the view of Kirkham (2010) suggesting 'fitting in' is influential in the failure of achieving autonomy, rather than one of 'with-woman', which instead promotes normality and remained essential to the practice of the participants (Hobbs, 2012). Although this is reassuring, participants often felt practice culture undermined their ability to achieve this, which is reflective of the dilemma. Conclusively, the study did suggest participants felt they were more able and prepared to challenge practice towards the end of their first year of qualification, therefore, enabling autonomy. Also, it is believed practitioners are able to dissociate themselves from conformity in practice as they grow in confidence (Hunter, 2004b), thus advocating autonomous practice. Interestingly, Hunter (2004a) identified the ideologies of 'with institution' and 'with woman' to be significant in relationships with colleagues, therefore, impacting self-esteem. Hunter (2004a) concluded those who idealised the 'with institution' concept were more experienced midwives compared with newly qualified midwives, which supports Parsons & Griffiths (2007) theory of socialisation. Equally important, it was established newly qualified midwives' practice can be deemed as submissive and compliant, as the authority of more experienced staff was rarely challenged (Hunter, 2004b). However, it could be argued the evidence within this study is bias and one-sided, as experienced midwives did not participate, therefore considering only the perceptions of student midwives' experiences. It is imperative, influential factors in driving practice towards conformity rather than autonomy are recognised, as it is believed newly qualified midwives often conform to institutional expectations (Hunter, 2009).

Upon reflection, the pressure I placed upon myself to maintain a non-intervention approach to care when caring for Faye was unrealistic. In particular, the criticism I placed upon my practice, as I believed I was unable to advocate the care I felt Faye deserved, due to lack of

assertiveness. However, even though I intervened this did not necessarily affect Faye's experience, as I discussed the examination with her so she was fully informed which supports Anderson (2010) study of women's birth experiences and intervention.

Furthermore, what has been highlighted while exploring this dilemma is the criticism I placed upon myself, even though the outcome of the situation remains positive; this is acknowledged by Kirkham (2010) who believes striving for such high standards of care can be damaging for both patient and midwife, often leading to a lack of job satisfaction and burn-out.

### **Improvements to practice**

This dilemma raised many points for consideration, in particular developing assertive behaviour to demonstrate how I could achieve autonomy. An Australian study researched experiences of graduate midwives, and analysed influences that promoted or impeded their development in the transition to qualification (Fenwick *et al*, 2012). In conclusion, within transition, support from colleagues and inter-collaborative relationships should be formed which in turn will promote increased confidence in graduates, to enable women-centred care. Also, it is suggested graduates were more able to challenge practice and promote normality if this is achieved (Fenwick *et al*, 2012). Sully & Dallas (2010) suggest in order for assertive communication to be successful, the practitioner must first develop confidence within the working environment where assertiveness is to be achieved; for me this was the obstetric unit. It is believed, assertion is an open and honest form of communication whilst considering other people's views and position (Potts & Potts, 2010) and as Sully & Dallas (2010) suggest is an essential element of proficiency. Therefore, it could be argued by using assertion appropriately within practice, there remains the common philosophy of women-centred care and so conflict should not arise, however, assertiveness can become

challenging when there is ward culture or working with experienced colleagues (Sully & Dallas, 2010). Hence, the development of this skill whilst I had the support of my mentor equipped my transition (Fenwick *et al.*,2012).

For this reason, I requested I take the lead when delivering parent-craft sessions and when discussing hand-over of care to experienced and superior staff; this further developed communication skills, which suggested by Potts & Potts (2010) allowed me to assert myself. Self-preparation such as this, encourages the development of assertiveness (Sully & Dallas, 2010) and allowed me to overcome barriers such as managers and ward culture, which can frequently prevent this (Timmins & McCabe, 2015). Working through this dilemma allowed reflection of practice, where I always strived for perfection; this highlighted I was overly self-critical and feedback from mentors had always been positive, although also suggested I should have had more self-belief. Consequently, I realised the need to acquire equilibrium between achieving normality and empowerment; I had placed a great amount of pressure on myself emotionally, in striving for Faye's desired outcome due to the relationship we had built. It is believed, midwives often place unrealistic demands on themselves to achieve job satisfaction however, midwives must consider realistic expectations and parameters when delivering care to protect themselves (McCourt & Stevens, 2009).

I believe reflection and continual professional development are paramount to the midwives role. Because of this, I kept a reflective diary to document events and situations in practice which I discussed with my mentor; to seek a way of learning from these as well as noting positive aspects of my practice which in turn, increased my confidence and discouraged me from being overly self-critical; a view shared by Hobbs (2012) which also prepared me for autonomous and accountable practice.

## **Conclusion**

In conclusion, this article has explored a professional dilemma I faced as a student midwife; to use VE to confirm full dilatation or observe the woman in labour supporting a non-intervention approach to care. There were three influential factors that became apparent; the medicalised culture of the unit; maintaining a trusting relationship with the woman and promoting empowerment, and assertive behaviours needed to achieve a 'with woman' approach in a medicalised unit. I undoubtedly ignored my own values when I used intervention to confirm full cervical dilatation when caring for Faye, therefore pertaining to a medical model of care and conforming to the culture of practice within the unit. As a result, I highlighted areas for practice development to equip me with skills to challenge practice, to avoid conforming in the future; a major attribute was a lack of assertiveness. Although I had the knowledge and skills to identify labour progression and promote normality, I did not assert my views effectively with the midwife who I was working with to avoid intervention, irrespective of physiological signs. It is clear, through exploration and analysis of literature and evidence, effective communication and interpersonal relationships with colleagues is paramount when wishing to achieve autonomy and assertiveness. Hence, I addressed these elements by organising some experience of leading parentcraft classes and work within an MLU; this improved my confidence within the work environment and in turn enabled me to act assertively and allowed me to practice with minimal intervention, and with those who held values similar to my own. Though I discussed empowerment, normality and 'woman-centred' care as being central to the midwife's role, I often held unrealistic expectations of myself which could have led to a negative impact upon my professional development. I ensured measures were taken to avoid such unrealistic expectations and continued to seek support from my mentor, and use reflection as a tool that aided my future development. With this in mind, it allowed me to be less self-critical and equipped me with

skills to improve and develop my practice; to give woman-centred care and therefore uphold my values through transition and beyond qualification.

**Keywords:**

Vaginal examination; Student midwife; Midwife-woman relationship; Assertive behaviours; Autonomy; Culture of obstetric units

**Key points:**

- Midwives face dilemmas in everyday practice
- Influential culture of working environments may contribute to creating dilemmas
- Assertive behaviours within midwifery can often achieve autonomy
- Self-reflection aids continual professional development and allows us to make improvements to our own practice

**Reflective Questions:**

- As a midwife, how would you tackle a similar dilemma in practice if you were working in a medicalised culture?
- Assertive behaviours can achieve greater autonomy. How can we prepare students to become more assertive for the transition to a newly qualified midwife?
- Assertive behaviour comes the ability to make independent decisions as it is considered a communication process that is vital to practice. Has there been a time within your clinical

practice you were unable to openly express your feelings, and how did you overcome this?

What support did you seek?

- A key role and underlining philosophy of midwifery practice are to be 'with woman'. How do we ensure midwives remain autonomous and what improvements to practice could be suggested?

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