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PREPARING THE MIDWIFE FOR THE 1980's

- IS SAFETY ENOUGH?

A conference held at the King's Fund Centre, on Monday 30 October, 1978.

A conference was held at the King's Fund Centre, London on Monday 30 October 1978 entitled 'Preparing the Midwife for the 1980's - Is Safety Enough?'

Miss N Hickey SRN SCM MTD, Area Nursing Officer, Coventry Area Health Authority was in the chair for the day. She welcomed the members and officers of the statutory bodies of the United Kingdom and all the midwives, and spoke briefly of the Nurse Education Research Unit at Chelsea College, where a midwifery project is being undertaken in two parts. This project is attempting to define the role and responsibilities of the midwife both now and in the future, and examining the educational needs now and in the future.

The introductory session of the forum was taken by Miss V Crowe, Senior Tutor, Royal College of Midwives, Miss J Worssam, Divisional Nursing Officer (Midwifery), Barking, and recently qualified midwives Mrs Gail Kimber of Greenwich District Hospital, Mrs Christine Mundy of Mayday Hospital Surrey and Miss Petra Sutton of the Southampton General Hospital.

Miss Crowe opened the session 'Present State of Play' by making an analogy with sport. She said that in sport strategy and tactics were looked at to see where improvements could be made. Obviously if we looked at these factors when we were dealing with people it was a much more serious event. She explained that Miss Worssam had responsibility for middle management and she herself had responsibility for midwives education. Gail Kimber told the forum that she qualified as a general nurse in New Zealand in 1972, and finished her midwifery training in August this year. She had been a staff nurse for four years in intensive care, surgical and orthopaedic nursing. Petra Sutton trained as a SRN at the London Hospital, Whitechapel and had worked as a staff nurse for nearly two years. She had qualified in Midwifery at the Southampton General Hospital in August this year. Christine Mundy had completed her general training at Addenbrooke's Hospital, Cambridge and had been a staff nurse in medical nursing for nine months. She too had qualified in midwifery in August this year.

Miss Worssam's first question was to Petra. She asked her what in her new role she found most enjoyable. Petra said that she had enjoyed getting back to being a staff nurse. She had found the worst part of midwifery was being a student and not feeling adequate with the patients. Her greatest concern, now she was qualified,

was the ability to cope with situations as they arose.

Christine was asked how she planned the day when she was in charge and what her priorities were. She said she tried to organise as much like Sister as possible, with the patient given first priority but she did not like the administration side.

Miss Crowe asked the panel if any had experienced any sort of in-service training since qualifying. Gail had been to one session since qualifying. The topics had been relevant, 'Coping with stillbirths and bereavement' and 'Analgesia in labour' by a Consultant Anaesthetist.

Petra had been to a Staff Nurses' Study Day. An Asian woman had spoken on how Asian women felt while in labour, and about Asian customs. This was valuable as Southampton has quite a large Asian population.

Christine had been to only one lecture. This was on mental subnormality and she had not found it relevant.

Petra was asked a question concerning the midwife's counselling role. How did she think she would be equipped to deal with problems such as stillbirths and bereavement? In reply she said that she did not think it possible to equip people to cope with bereavement, you had to learn to deal with the situation when it arose. This is one of the most difficult problems facing midwives. Gail said she would look at the history of the parents in an attempt to help. She agreed with Petra that it was a situation for which you could not be prepared adequately. She felt the most difficult part was trying not to become involved and show your emotions. She said it might help the mother if you had a good cry with her, but you had to think of the other patients.

Miss Crowe asked the panel whether any of them had experience from their general training which helped them in the counselling role. Gail said that her work at the Royal Marsden Hospital, where she had watched more senior people coping, had helped her in the maternity situation.

Miss Worssam introduced the problem of the abnormal babies. This could involve counselling work. The question arose of who said what to the patients, and there was the importance of records if there was some redress about the abnormality. How were they

prepared for this situation? Christine felt she was 'thrown in the deep end', that you were just there as it happened and there was not much you could be taught in advance. She said that although she was told that the Paediatrician would explain the situation to the parents, he was not there at the beginning, the midwife was there so she must talk to the parents.

Petra had only seen one case of abnormality, a double hare lip, and in this case the parents were shown 'before and after' photographs. Petra said that she had learnt this idea in her training.

Miss Crowe then asked the panel how well they felt they had been prepared to teach in the clinical situation. Christine replied they had not been taught well enough. One instant they were learners and the next teachers. Petra said that in her training school they had been encouraged as senior students to teach in order to help with their revision. This was at first carried out under a midwife's supervision and very helpful.

Gail's comment on this subject was that she found it difficult to explain herself clearly when teaching. She was still very occupied coping with the ward administration, and it was hard to find opportunities to teach.

Miss Worssam's next question was on a different topic - did the panel feel vulnerable when talking to people about Unions? There was not much comment in reply to this, but Petra felt that the Unions should be handled very gently because of their power.

Miss Worssam then went on to the topic of child abuse, and asked Gail if she had any views about this in her role as staff midwife. Gail thought that preparation should stem from antenatal care where expectant mothers could be given some idea of what their roles as mothers should be. As much as possible should be done to create bonding between mother and child to help to reduce child abuse. In the post-natal period Gail felt midwives could help in detecting by observing potential families where child abuse might occur, and transferring this information to the health visitor.

Miss Worssam summed up the introductory session briefly by saying that a number of problems had been identified for which staff midwives needed preparation.

Miss Hickey next introduced a panel of recently qualified midwives who spoke about their training and how it had prepared them for their professional role.

The first spreaker was Mrs Baines, Midwifery Sister at King's College Hospital. She explained that at King's College Hospital additional facilities were offered to obstetric patients. The student midwife might be introduced to these during her training but they were not part of the curriculum. These facilities included complex ultra sound scanning studies, fetal breathing studies, fetoscopies and research into family planning, including infertility and the use of the contraceptive injection. Patients expected the student midwife to know about these subjects. Mrs Baines felt there was a lack of obstetric theatre experience in the training and that more was needed. She said clinical teaching played an important role at King's College. The student midwives were encouraged to teach from an early stage in their training, and when qualified as midwives. She commented that people might teach in different ways depending on their personalities. Some might like an active form of teaching using visual aids, while others might like to teach in a more passive way by example in the clinical situation. The student nurses on obstetric courses had to be taught as did the medical students. Mrs Baines felt the medical students needed a lot of encouragement, especially on the labour ward, to look after patients and form relationships with them. She said the support of medical students could be difficult without liaison with medical staff, and this was not always available.

The counselling and psychological support of the patients and families was part of the midwives' training. Some of this was taught in general nurse training and the ability to give this support improved with experience. Mrs Baines commented that she thought some patients related to married midwives better, especially on the subject of contraception. She felt that the counselling of patients was not covered adequately in training, especially concerning the single obstetric patient, but there was plenty of opportunity to become involved with these patients on the wards.

Mrs Baines went on to talk of research at King's College Hospital. She said there were various projects in operation especially concerning fetoscopies in the first trimester of pregnancy. Fetoscopies could present a dilemma for patients, midwives and doctors. Many were carried out for research followed by termination

of the pregnancy if desired by the patient when abnormality was detected. Some were performed to exclude hereditary disorders such as thalacaemia and haemophilia.

A problem at King's College Hospital was that owing to a shortage of space the fetoscopy room was directly opposite the delivery room. This could be very disconcerting especially when the late termination of an abnormal baby was involved.

Another research project at King's College Hospital was a trial of dexamethasone for use in premature labour. The patients were given a course of the trial drug - the midwife did not know whether the drug or a placebo was being given. Mrs Baines then questioned whether the doctor or nurse was responsible to the patient. She said if the nurse was responsible why was she not given the chance to be involved in the ethics of a project such as this?

Everywhere there were great changes in action such as fathers present at the delivery, caesarean section under epidural,and male nurses on obstetric courses. A modified Leboyer method also had been introduced after a controlled study at King's College Hospital.

Mrs Baines spoke of the many groups and organisations which she felt acted as a stimulus to midwives and filled in gaps in antenatal care. These included the National Childbirth Trust, Birth Centre, and Association of Radical Midwives.

Mrs Baines concluded by saying that in spite of her criticisms she felt her training had been varied and good. She stressed that the views expressed were personal and not necessarily those of colleagues and superiors. She was thankful her tutors had encouraged her to have a broad outlook and keep abreast of current attitudes and changes.

The second speaker on the panel was Miss Bowden. She had qualified as a midwife in February this year. She had qualified as a general nurse in 1971 and had been a fourth year Sister before starting her midwifery training. She had worked mainly in gynaecology.

Miss Bowden was practising as a Staff midwife in Reading. Here she said there were many Asians and therefore communication problems. Some Nursing Auxiliaries were Asians and were able to help with interpretation .

Miss Bowden spoke of the problems in her training concerning the nursery nurses. She said the Consultant Unit where she trained

took many NNEB Nursery Nurse Students from Training College and private nursing homes. The students obviously looked after babies, and this could mean the student midwife had to look after the mothers, and therefore had very little involvement in the care of the babies. She said because of the staff shortages the student midwife felt sometimes she was just 'an extra pair of hands', and this was not conducive to a learning situation. She, like Mrs Baines, spoke of ethical issues involved with, for example, tests for alpha feto proteins. Miss Bowden went on to talk on some research with which she and other midwifery staff had been involved concerning the psychological angle of midwifery. It was found that however often a patient was given information this did not always 'register'. Her training had given her a chance to learn about the psychological angle of midwifery, but she realised she had considerable experience as a Sister and may have acquired such knowledge before. Other midwives with whom she had discussed this issue felt their training had been lacking in the teaching of psychological aspects.

Miss Hickey commented that she was interested to hear about the lack of theatre experience in midwifery training and thought this probably applied also to general training. Mrs Baines agreed and said she felt that an effort must be made to include more theatre experience in the curriculum. She said that most Caesarean Sections were emergencies and it was often difficult to teach adequately under such circumstances and so student nurses and student midwives could become frightened of theatre experience.

Mrs Baines was asked a question from the floor concerning the ethics of research - did she want the staff midwives involved in the project to be consulted, or did she feel a staff midwife should act as midwives' representative? Mrs Baines said she felt there should be a representative whom the doctors consulted, and she should discuss issues with all the midwives involved. The floor speaker commented that it seemed very sensible to have informal discussion among the people involed as an extra to any formal ethical committee.

Another speaker from the floor, a direct entrant to midwifery training, asked what the panel felt about their length of training. Mrs Baines felt it was adequate when she trained - she had taken Part I and Part II training; but now she felt more was needed as there was so much change. Both Mrs Baines and Miss Bowden thought two years was too long, and would discourage people from training.

In an interlude between panel speakers Mrs Gilbert told the forum of her experience when having her baby, Kate. She explained she had been a counsellor at Guy's Hospital London for four and a half years, and had a great interest in the interpersonal side of nursing. She was SRN RMN and had completed a three months obstetric course. She became pregnant for the first time when she was thirty-two. Most of her pregnancy had gone well. However, at thirty-four weeks she had been admitted to Lewisham Hospital with toxaemia. This, she said, had been a 'terrible blow' to her. At thirty-six weeks she had an induced labour under epidural. Kate had been a 'small-for-dates' baby and had been in the Special Care Baby Unit. Mrs Gilbert had spent five weeks in hospital.

Mrs Gilbert explained she had divided her talk into three parts - 'before', 'during' and 'after'.

Mrs Gilbert had attended both her Doctor's surgery and the hospital for her antenatal care. She had been impressed by her first visit to the antenatal clinic, but not by subsequent visits. There was no appointment system and hours of waiting. She saw different people each time. She said there appeared to be very little supervision of student midwives by teaching staff. Mrs Gilbert felt the student midwives could have been encouraged to be more involved, and this would have mitigated some of the waiting and delays and impersonal atmosphere of the clinic. She felt clinic visits could have been made happier experiences, and more effort made to allay her anxieties. Tests were not explained to her, and although she considered herself an articulate person she found she did not ask the questions she had wanted to. This had shocked her. She realised the patient does not take in what is said, and felt that patients suffer more bad experiences than nurses are aware of.

She went on to speak of her experiences in the antenatal ward. On admission she said there was no attempt made to explain what sort of ward she was in. She discovered it was a ward containing many patients with rhesus incompatabilities who had few live babies among them. She had been put next to a patient who had lost four babies and talked incessantly about this. Mrs Gilbert had been told 'no one knows about toxaemia Mrs Gilbert - you've just got to be calm and not get anxious', and in the next bed there was this lady talking continually about her dead babies!

Mrs Gilbert explained that she was eventually moved to a side ward at about thirty-six weeks when she told the doctor she could stand no more. She felt the staff had become immune to how much this lady was upsetting the patients as they were so used to her. Mrs Gilbert was very used to anxiety from her counselling work, but she found she could not cope in the 'consumer role'.

Mrs Gilbert stressed the need she had felt for an experienced view about her condition although in fact the relationships she enjoyed most were with the student midwives, they could relate to her and chat. Nobody, she said, seemed prepared to do more than chat and she badly needed counselling, somebody to take time to find out what she was worrying about and try to sort out her feelings. Instead, totally useless comments were made, such as 'you could be worse', 'if you just keep calm everything will be alright'. Equally useless were the generalisations made, even if done with kind intent, such as 'everybody feels like this' and 'no need to worry'. It was obvious there was reason to worry or she would not have been admitted to hospital. Mrs Gilbert emphasised she badly needed someone to ask directly 'what's worrying you?' instead of just trying to soothe in this totally inadequate manner. She said she realised, being a nurse, how difficult it was to know what to say in certain circumstances such as these. She disagreed with the speakers who said earlier in the conference that they felt preparation for these situations was not possible. Mrs Gilbert said,'there has got to be a better way than just going with things as they happen, and hoping that you'll say the right thing when you've had enough experience.

Mrs Gilbert went on to talk of her experience during labour. This she said was a very good experience, and she was very grateful to the midwives involved. At one time there were about twelve people in the delivery room and they were cheering her on to deliver because it seemed as if she might need a Caesarean Section. She and her husband were at this stage given as much information as they wanted and they were asking a lot of questions. One interesting point that Mrs Gilbert made here was how hard she found it to become involved with the midwives, as she only felt concerned for herself. She had to make a real effort to remember the midwives were human beings and take some interest in them.

Looking back at the period after her baby's birth Mrs Gilbert said she remembered two main issues. Firstly the isolation she felt.

She said she longed to have her baby with her, but did not like to admit to this as she felt she should be grateful that Kate was alright. Again she felt the need to talk about this to one of the staff, as the other mothers naturally wanted to talk about their own babies. The second point about her time post-natally was that she fell between the two categories of 'patient with a baby' and 'baby'. She felt that the ward nurses thought that she could manage, and the nurses on the Special Care Unit were involved with the babies and she sometimes felt superfluous. Mrs Gilbert recounted how she became exhausted by her day's schedule, dividing her time between her baby on the Special Care Unit, and getting back to her ward for meals. No one noticed her exhaustion until she collapsed. Mrs Gilbert emphasised that she was very annoyed that this exhaustion was attributed to 'baby blues'. She said that it seemed that the only psychological point which nurses generally seemed to accept was that mothers got depressed. Mrs Gilbert said that she did not get depressed and she knew other mothers who had not suffered from depression. She said her exhaustion was purely physical, her schedule left her with half an hour in the morning and in the afternoon to herself. Mrs Gilbert appealed to the midwives to have a wider outlook on the psychological angle, and not just assume that an exhausted mother was just feeling depressed.

Mrs Gilbert concluded by saying that on the whole she looked back happily at her experience of having Kate.

Mrs Gilbert was asked how she felt about having twelve people watching her delivery. She said that she did not worry about this at all, and she had been asked if she minded them being present.

A second questioner asked if it would have helped to have Kate in an incubator by the bed to avoid all the travelling to and from the Special Care Unit. The answer was an emphatic 'yes'.

Mrs Gilbert was then asked if there was any stage of her pregnancy, labour or post natal period when the presence of a male midwife would not have been acceptable to her or her husband. She replied that she felt neither she nor her husband would have objected to a male midwife at any stage.

The next floor speaker said that she was interested in Mrs Gilbert's contrasting experiences in the antenatal and labour wards. It

seemed that part of the problem might be that Mrs Gilbert was getting answersto her questions during labour, but had not felt able to ask questions antenatally. The questioner asked why there was such a contrast in the same hospital.

Mrs Gilbert replied that in the antenatal period she would have liked to question the doctors, but the Registrar she saw twice in the antenatal clinic did not like giving explanations to patients. Mrs Gilbert went on to tell of her bad experience of this Registrar post-natally. He had seen her for about two minutes. He had rushed into her room, delivered statements about her age and condition, and left her in a sorry state. After she had recovered she asked to see him and told him she felt his behaviour was an extremely poor way to treat a patient. She had been frightened when confronting him as she felt in a vulnerable situation. When she told the other patients about this they said he had left several mothers in tears after his ward round. Mrs Gilbert made a very important point here when she stressed that the ward sister had been with this Registrar on his round. So, Mrs Gilbert asked, where was the professionalism that midwives wanted to have attributed to them?

Although midwives and nurses liked very much to be treated as professional people when it came to standing up as professionals in the face of doctor colleagues they were not good at all. They tended to take the easy way out. She said she felt if the nursing staff had intervened antenatally and post-natally she might have found it easier to ask questions.

After this session with Mrs Gilbert the panel resumed their talks.

The next to speak about her training was Mrs Maiden from Scotland. Mrs Maiden said that to apply for midwifery training the applicant must be a Registered General Nurse or the equivalent. Some hospitals accepted enrolled nurses. The training in Scotland was a full year.

Mrs Maiden explained that the Fife School of Midwifery where she trained, worked with two hospitals, the Forth Park Maternity Hospital, Kirkaldy and the Dunfermline Maternity Hospital, Dunfermline. The training school took about sixty students each year in four intakes. At Forth Park there were eighty-five beds, twenty-five Special Care cots and an average of two thousand five hundred deliveries each year. At Dunfermline there were

fifty beds, eighteen Special Care cots and around one thousand five hundred deliveries each year. Both hospitals were fully integrated with the Community Staff.

Mrs Maiden trained at Forth Park from March 1977 to February 1978, and worked for eight months as a Staff Midwife on the Delivery Ward. She felt her training had been good and equipped her well to practise as a midwife. During her practical experience on the Delivery Suite she had delivered forty babies, (twenty deliveries were compulsory) performed twenty five perineal infiltrations and episiotomies (five compulsory) and carried out fifteen vaginal examinations (ten compulsory). She had also witnessed ten normal deliveries and ten abnormal deliveries. So she had completed more than the required practical experience.

At Forth Park, Mrs Maiden explained, all student midwives had two allocations to the antenatal, delivery and post-natal wards, and one allocation to Special Care Nursery, Clinics and domicilliary visiting. For each allocation there were set objectives. Each area had a copy of these objectives so that the students, clinical teachers and midwives knew what must be covered.

During the first antenatal allocation the student midwife learned to differentiate between normal and abnormal pregnancies. During the second allocation she consolidated this knowledge and began her teaching role by teaching student nurses, and conducting antenatal classes within the department.

Mrs Maiden went on to talk of her post-natal training. During the first allocation the student midwife was taught to nurse mother and baby in the immediate post-natal period. During the second allocation she continued to do this and learned to anticipate and recognise abnormalities. She also taught junior students, and gave post-natal talks under supervision of a midwife.

The objectives of the first allocation to the delivery floor were to become familiar with normal labour, spontaneous and induced, and the necessary observations. Also to become efficient in spontaneous vaginal deliveries. On the second allocation the student would be prepared for her work as a staff midwife. For example she might be left in charge of three cases with a junior student. She conducted deliveries and wrote up the notes, and she learnt the resuscitation of babies. She taught patients to cope with labour and advised junior student midwives. On allocation to

the Special Care Nursery the student learnt the basic care of small, ill and potentially ill babies.

Mrs Maiden said that for clinical experience the student midwife attended antenatal, post-natal, paediatric, child welfare and family planning clinics. She learnt the value of keeping records accurately, and the importance of encouraging attendance at clinics. During domicilliary experience the student witnessed the pleasures and difficulties of coping with the new baby at home.

Mrs Maiden felt that if all these objectives were covered and she thought they were during her training, then the newly qualified midwife was very well equipped to practise. She found it very helpful to have these set objectives during her training.

One thing was lacking. Although she taught as a student midwife teaching methods had never been explained to her.

Mrs Maiden said she felt that mothers and their families needed a lot of support when the mother was in hospital. She had learnt in training and by experience the physical and emotional changes in the pregnant woman. She emphasised the importance of understanding these to be a good midwife, and she felt more teaching should be given on how to cope with situations of emotional stress, for example the mother caring for a mentally or physically handicapped baby, or the woman who had an abortion or stillbirth.

She felt there should be more teaching in and more psychology discussion about women's reactions to difficult labours and deliveries, and whether these babies were at risk from their parents.

In concluding her talk Mrs Maiden summerized by saying she felt more teaching should have been given during her training on teaching methods, psychology, and the counselling of mothers. The training would need to be expanded to include these topics. More time was needed to prepare the student for the change to staff midwife, as a fair amount of supervision was necessary when first qualified.

The fourth speaker on the panel was Mrs Sloan from the Jubilee Maternity Hospital, Belfast. She had qualified as a staff midwife in 1975. Mrs Sloan said that when considering the question 'Did my training equip me for my subsequent role as a practising midwife?' the answer was partly 'yes' and partly 'no'. She felt there were certain limitations associated with the present one year system. Mrs Sloan explained that there had been a

significant reduction in the training period with the introduction of the single period training - this had been implemented in Northern Ireland in 1972. Also the training period had been eroded further by a reduction in the working week and increase in statutory holidays.

Mrs Sloan said that during training the learner was allocated to different clinical areas, and settling in and gaining knowledge and experience could be difficult when the allocation was only for a short period such as two weeks. When developing new skills there should be a time for the necessary theoretical preparation. The study day content was not always related to the practical experience being gained at that time by the students. However the study days had the advantage of ensuring regular contact with teaching staff and allowing time to absorb new knowledge. Altogether about seven weeks were spent in school and Mrs Sloan considered this a very small proportion of the training period when so much progress and change was taking place in midwifery. More emphasis was needed on the psychological skills of dealing with mothers, relatives and whole families.

Mrs Sloan then spoke of the midwife's important role as a teacher. She said teaching was a very complex and skilled art. Since qualifying she had become aware of the importance of certain aspects of teaching, for example the careful planning not only of content but also of methods, teaching aids and evaluation. She did not think her training prepared her adequately for the teaching role.

A further point about her training which Mrs Sloan raised was that of assessment. She felt learners should be assessed regularly not only for educational reasons but to give the learners a sense of progress. She said there was a frequent assessment of knowledge which gave motivation for continuous study, but felt there was really no means of assessing practical skills.

Mrs Sloan said that with the coming of the new training scheme, which it was hoped whould shortly be introduced in Northern Ireland, the training programme would be lengthened to seventy-eight weeks. There would be longer allocations and more emphasis on psychology and teaching. Also theory and practice would be related by the introduction of a modular scheme. Each module would be evaluated with a written examination, a practical assessment and ward progress reports. Mrs Sloan felt this extension to the present training

was definitely needed.

The final speaker on the panel was Mrs Warwick who worked as a Community Midwife in South West London. She said her work covered all aspects of midwifery - the antenatal and post-natal periods and labour, plus much parentcraft teaching, teaching in schools and teaching student midwives. She also took part in running a community ward, and the community was closely integrated with the hospital staff. The aim in the community was total patient care.

Her general training had been an integrated degree course in Edinburgh and her midwifery training had been a one year course in London. She felt that on the whole the two trainings had equipped her well for her present work, but there were areas where she felt additional training would have been helpful. She also realised her general training, with its emphasis on community and preventative medicine had given her some very useful knowledge which other general training schemes might not have included.

Mrs Warwick talked about four main aspects of her work and pointed out where she felt additional training would be helpful. These four aspects were - teacher, advisor and counsellor; involvement in legal and ethical issues, and clinical nursing.

Mrs Warwick felt her work as teacher was probably the most important aspect of her present job. She said although all midwives taught and had the knowledge to do so, she questioned whether they had the ability to impart this knowledge to varying groups of people. She thought that newly qualified midwives did not know enough about educational principles and methods, although their knowledge varied depending on previous careers and experience. She felt the basic training should include lectures on how people learn, the psychology of learning, teaching methods and teaching aids. If there was not time to include these topics in the training then every midwife should have the opportunity to attend a course on these subjects soon after qualifying. Mrs Warwick said her own training had helped in this area, because in her Community module she had participated in parentcraft sessions and heard others conducting them. But although this was a very good practical training more theory would have been helpful for her current post.

Mrs Warwick said that alongside her teaching role was that of counsellor and advisor - giving psychological support to mothers

and families. If a mother had a problem in the antenatal clinic the community midwife would be asked to visit the home to clarify the mother's worries. But Mrs Warwick questioned whether the midwife had sufficient training to enable her to do this aspect of her work well. She said 'Is our advice and counselling to be based on factual knowledge and will it be impartial, or are we just going to impart our own feelings and prejudices to the mother. In other words do we really know how to advise and counsel when we are qualified as midwives?'

She felt there was a need for midwives today to understand social and environmental issues to understand different social classes, different cultures and the role of the family, so every mother could be seen in relation to her total life style, and advice and counselling given appropriately. The midwife needed to understand better the role of all other health workers, social workers and teachers so she could refer the patient to receive even more appropriate advice. Lectures on counselling and inter-personal relationship skills should be part of the basic training course. If this was not possible courses should be available to newly qualified midwives. General training helped a lot in relation to social issues and studying the family, but not with counselling skills.

We live in a very litigation conscious society and every newly qualified midwife should understand fully what the implications are of her owing a duty of care to her patients. Talks on legal issues should be incorporated into the basic training, and the importance of record keeping and of communicating with other health workers should be stressed. Both her trainings had made her aware of the need for good record keeping but perhaps not fully aware of legal issues. Since qualifying she had been given opportunity to attend lectures on these subjects, but she would have liked this knowledge when first qualified. Mrs Warwick underlined the importance of ethical issues. She felt there should be opportunities for midwives and student midwives to have open discussions on all ethical issues, to hear opinions from appropriate workers, to consider the religious side and the psychological side. There should be a lot of debate on these topics so those involved could formulate their own opinions and ideas.

Finally Mrs Warwick considered her role as a clinical nurse, and whether her training had equipped her well. On qualifying she

had lacked confidence in herself as a midwife. She had not been used to decision making and felt midwives must give student midwives some responsibility. She thought her training had made her a good technical midwife, but questioned whether it had made her a good basic midwife. She wondered if she had looked after too many patients on monitors, and with epidurals, and whether it would have helped her if her training school had been linked with General Practice units or if her community experience had been longer. It was during her community experience she saw normal labours. Mrs Warwick felt there was as much need as ever to be a good basic midwife, especially in the community and this should not be lost sight of amid all the research and progress that was going on. This could give rise to a dilemma in that places large enough to be training schools had a lot of technical equipment and research. She thought student midwives should be taught the skill of suturing, and also that they should be taught more than the theory of family planning. She felt it would be useful if midwives could fit coils and prescribe the Pill, as they were often the people most involved with girls who did not readily attend Family Planning sessions.

Mrs Warwick's last point on the clinical side was that there was a very strong need for student midwives to be made to appreciate the importance of keeping up to date with current research on both large and small issues. She made a very significant point - 'All advice midwives give should always be based on theoretical knowledge and theoretical research.

In conclusion she said that by adding these topics she felt newly qualified midwives would be better equipped for work in the 1980s.

A time for questions from the floor, and discussion followed this session. Two questions were of particular interest.

Mrs Gilbert was asked what could be done to avoid her situation during her antenatal stay in hospital of being next to such a worrying patient.

Mrs Gilbert felt that other patients were often left to hear all the anxieties of a patient such as this, because the staff were busy or chose to be. She thought there were many opportunities when staff could have spent time with this patient. She realised from her time as a nurse that such patients were tedious and it was hard to feel empathy for them. She felt that if the student

midwives could be given some experience of counselling skills, then such a patient could be cared for more successfully, and would not have felt the need to use other patients in the ward to work through her own difficulties.

The second question of special interest concerned breast feeding and was addressed to the whole panel. They were asked who in the post-natal ward situation had given them the clinical teaching of assisting mothers in breast feeding, and whether this teaching was given in the light of up-to-date research on the subject.

Miss Bowden and Mrs Sloan said that they had learned the assets of breast feeding in school during midwifery training, and had gained practical experience helping mothers on the post-natal wards under the guidance of a sister or staff midwife.

Mrs Baines had been introduced to breast feeding in her antenatal training. She had been encouraged by the sisters in the ante-natal clinic to talk to mothers about breast feeding and care of the breasts. When the students reached the post-natal wards it was generally the senior person on duty who showed them how to help the mothers with breast feeding.

Mrs Warwick said that the sister on the post-natal ward had showed her how to help mothers with breast feeding. But she emphasised how much she was in favour of the post of lactation sister. Since qualifying a lactation sister had very much improved her ability to help breast feeding mothers by teaching her a great deal of up-to-date research. This lactation sister had taught the hospital and community midwives.

At Forth Park where Mrs Maiden trained they had a lactation sister. The student midwives usually spent one or two weeks with the sister quite early in their training. She felt this equipped the students well for helping with breast feeding, but that the ability to help improved practice.

Mrs Gilbert wished to add some comments on this topic. She said she had suffered a lot of problems over breast feeding because of conflicting advice all the time. Lewisham had a lactation sister. It was a new post and the sister was caught between patients and staff. Staff resented what they felt to be an eroding of their role. They wanted to be involved with care of the breasts and breast feeding. But Mrs Gilbert said she found the lactation sister a 'Godsend' because she really seemed to care more for the

mother during breast feeding than the baby. Mrs Gilbert said although she had realised how important it was for her baby to get the milk she had sometimes nearly given up breast feeding. This was because the Special Care staff and doctors had been so concerned the baby got her milk that they worried if Mrs Gilbert was not 'doing it right'. Mrs Gilbert said she supported the post of lactation sister very much indeed.

Miss Hickey summed up the morning session. She noted that medical staff had been mentioned several times, and the lack of support from them. On the research side comment had been made about drug research in particular and the fact that nursing staff were not fully involved. They were just there to assist and might not know where the research would lead. Perhaps they should participate more on research committees.

She felt that when Mrs Gilbert was talking people might think such situations did not happen in their own hospitals. But she asked people to consider very carefully the points Mrs Gilbert had made. Nurses and midwives might think they were giving good care but they did not always know what the patients were feeling. Mrs Gilbert had used the words 'staff become immune', and Miss Hickey said staff must be aware of the danger of this happening.

Miss Hickey also reiterated the problems of isolation and exhaustion which Mrs Gilbert had encountered.

Other significant aspects mentioned during the morning were the usefulness of objectives during training; students not being taught how to teach or about teaching methods, and the lack of teaching about psychology.

Miss Hickey ended her summary by re-emphasising the need for student midwives and midwives to keep up-to-date, and she urged those present to think very thoroughly about this.

Summaries of group discussions following the morning session.

GROUP ONE

Task: Clinical Practice Skills

As a major part of a midwife's role involves practical ability and competence the Group is asked to:-

a. identify the practical skills that should be taught in basic midwifery training and a level of competence that should be achieved;

b. suggest the criteria essential for effective learning of these skills;

c. consider the extent to which practical skills may be improved or new ones acquired following qualification as a midwife.

a. This group had included emotional and educational aspects in practical skills. The first practical skill listed was communication in the verbal and written form, and in the non-verbal, listening form. They felt the level of competence the midwife should achieve here was that she should be able to express herself clearly; maintain completely accurate readings and make the patient feel confident and at ease.

The second practical skill considered was history taking. The history taking must be accurate and complete and its significance understood.

The third practical skill was the assessment of the patient's condition and significance of the findings. They had broken this down into medical, obstetric, paediatric and social conditions. To be competent the student must know what was normal, be able to detect the abnormal and give simple advice and refer abnormalities appropriately.

The group had then discussed specific tests. They felt the student midwife should be able to perform a venepuncture, and must know the indications, significance and dangers of other specific tests in pregnancy. They felt the student should be able to plan and conduct a parentcraft course. By the end of her training the student should be able to prepare a comprehensive plan for parenthood, be able to demonstrate her ability to communicate in the one to one situation and in small groups, and be able to prepare small and simple visual aids.

Another practical skill the group felt the student should develop was the ability to convey information regarding maternity and

related benefits and services. She would be competent when she could explain various benefits to patients, their eligibility for them and methods of application.

The group also thought, if this was possible in an eighteen months' training, that the student should be able to prepare for a clinic, prepare a clinic programme and cope with appointments, defaulters and notes.

b. The group felt one of the most difficult criteria for the effective learning of these skills was the good selection of the permanent staff, having sufficient staffing levels, and employing a good proportion of full time staff. They felt this would require a review of the establishment. There should be a planned time for teaching, and time for students to practise what they had learned and to discuss difficulties. Midwives, students and medical staff must appreciate the importance of antenatal care and there must be understanding of group dynamics.

c. The group said skills would be improved by practice, and they had discussed the possible period of supervised practice. They thought it necessary to have on going discussion of procedures, and to question established procedures. The group had talked about an in-service training programme, and ways of stimulating trained staff to update their knowledge and pay attention to pressure groups and the mass media. Other topics discussed were, sharing skills from specialist departments; rotation of staff within a hospital and between hospital and community; the value of perinatal meetings; demonstration of new equipment and using self assessment to judge clinical performance. There should be self appraisal, management and practical teaching courses as soon as possible after training was completed.

GROUP TWO

Task: Clinical Teaching Skills.

Among the midwife's many accomplishments she must be able to teach. She is responsible for teaching parents, relatives and pupil/student midwives and other learners with varied educational and cultural differences and therefore the amount of teaching and the levels of communication will vary according to circumstances. The Group is asked to consider :

a. the skills required to enable the midwife to fulfil her role as a teacher;

b. the extent to which the teaching of these skills should and could be included in basic midwifery training;

c. what further preparation for teaching in the clinical situation would be required following midwifery training and at what stage it should be obtained

a. The group decided that for a midwife to fulfil her role as a teacher she must first be a capable midwife, and must have a very broad and extensive knowledge of her own subject. She must endeavour to keep up-to-date with modern methods and have a motivation to teach. She should have the ability to communicate including awareness of details like voice and appearance, and be able to give clear explanations to questions. She must be approachable to both students and mothers. Another important factor was the ability to recognise needs within a situation, and to recognise teaching and learning situations when they occurred. The midwife should have the ability to stimulate interest and enthusiasm among the students.

The group felt that the midwife must have very good organisational ability in order to arrange teaching in her working day, and must have some technical skills so that she could teach students about new equipment. It was pointed out that the ability of student midwives had changed over the years, for example general training now was different to training in the 1940s,'50s and'60s, and more student midwives now had degrees. Thus the midwife must be aware of the different needs and abilities of the students.

b. When considering the inclusion of teaching skills in training, the group members felt this was important but must not supersede the basic training which aimed to produce a capable midwife. They agreed the twelve months training was too short. They thought the students could be helped by recognising that all learning and teaching situations were interdependent. Also, that self learning should be stimulated, by working in groups learning from each other and parents in parentcraft classes. They should learn how to research, and to a certain extent could participate in their own curriculum, discussing needs which they felt to be important with their tutors. The group felt students should be introduced to counselling in relation to staff and patients. There

should be wider discussions on ethics, for example the attitude of people involved with a stillbirth and the legal, medical and practical requirements of a midwife in this situation.

The group said that at all times the midwife should be made aware of the needs of each individual within a learning situation, and that flexibility should be encouraged.

c. The group agreed that central courses such as management and clinical teaching courses were important but were expensive. Courses which would embrace hospital and community midwives, and give an introduction to the principles of clinical teaching. Although refresher courses were organised for midwives, it would be helpful if hospitals provided smaller refresher courses perhaps on a day release basis. Both these ideas could be seen as self-learning situations, and help midwives to recognise the needs of themselves and others. They felt midwives would also recognise their resources within the area. The length of these courses was not decided. It was felt day release courses would be better than a block system, with perhaps the introduction of projects between study days.

A brief mention was given to staff appraisal as a useful means of identifying strengths and weaknesses in a person's teaching ability. As to when this should be introduced the group felt the newly qualified midwife needed time to consolidate what she had learned as a student. They felt six months was the minimum time any midwife needed to gain experience and confidence as the person in charge of a given situation.

GROUP THREE

Task: Counselling and Interpersonal Skills

There is an increasing need for the professional to develop counselling and interpersonal skills in order that an adequate service can be given to patients and other clientele.

The changes in family structures and society, the rapid development of technological and scientific techniques have all demonstrated the need for more knowledge in order that the psychological and emotional needs of people might be met. It is evident that leadership, managerial and counselling skills are important for the midwife.

a. Have the participants shown a need for further development of these skills before qualification? If not please identify

the need.

b. How should these be taught and by whom?

c. How much allowance should be made for the student midwife's previous social and professional experience.

The members discussed the problem of conflicting advice, but no one had found an answer to this. They felt in order to meet the patient's needs, consideration must be given to the needs of the staff. They discussed training in counselling and wondered if people should perhaps be trained to find out their own skills and develop them, rather than all be expected to counsel.

The group felt that the panel speakers had demostrated their ability to cope in a variety of situations, but wondered whether or not this was a good thing. It could place a stigma on those who asked for help and implied they were not coping. Often people did not admit they were unable to answer questions, and would fluff their way through situations instead of referring to others.

The group agreed there was a need to include counselling in the basic training, but that preferably this should be in practical situations. The situation of lactation sister was felt to be a good one for training in counselling, and they thought it good to spend time with the lactation sister, as one of the panel had, during training. The principles of counselling should also be taught, perhaps, to newly qualified staff rather than during training.

The group said that newly qualified staff were in a very vulnerable situation. If support was given at this stage many midwives might be lost to the profession. Another point made was that there was a great need to learn to listen when counselling in order to enable people to work out their own solutions to problems.

Finally the group re-emphasised the importance of enabling people to talk, of being approachable, and of the need for awareness in a changing situation.

GROUP FOUR

Task: Ethical Issues.

There are an increasing number of professional and personal dilemmas as scientific advances are made, and moral values and standards are questioned. The Group is asked to:

a. identify specific ethical issues in relation to midwifery;

b. consider whether or not it is essential and/or desirable

to face student midwives with the challange of ethical issues;

c. discuss the ways in which the training programme could be organised to provide both the theoretical knowledge and practical support which the student midwife might require to cope with crises arising from ethical issues.

a. The group felt students should be encouraged to develop their own views on these topics. Some of the issues discussed were termination of pregnancy, screening of patients for abnormalities, and whether patients should be told when they are screened.

The group also discussed the problems of the handicapped child; whether to treat or not to treat, for example, resuscitation and feeding, with particular reference to the staff in Special Care Baby Units and the problems of turning off respirators. The group had talked about how doctors would define stillbirths or abortions; trials of new drugs; research with or without patients' and staff's permission; social inductions; babies for adoption and who cared for these babies while they were in hospital - should the mothers or the staff?

b. The group decided it was inevitable that students would come across these problems during training. It was felt problems could be partly overcome by joint decisions with medical and nursing staff. Student midwives should know the law with regard to patients and the issues involved. Many student midwives had already met these problems during their general training. The group felt that very often, until the student was in a position faced with certain decisions, she might not be able to forsee the problems or might not know which way her mind would decide. The group said that if a nurse was known to have strong views these must be respected. For example, if termination of pregnancy was against her religion, then her views must be sought before asking her to work in theatres where these terminations were carried out.

c. The group felt these topics were best discussed at moments in training when they arose, and not so much as separate items on the programme. Some discussion occurred on the wards, for example at time of report and during night duty. it was also felt that discussion groups led by tutors were

quite useful. The tutors said that a session towards the end of the training on ethical subjects should be introduced in case many of these subjects had not been covered during training.

GROUP FIVE

Task: Adapting to Change.

Change is inevitable and it is probably true to say that until recent years there has never been so much change so quickly. It has also been stated that the midwife accepts change in midwifery practice resulting from changes in medical practice without challenging the change or being given a choice.

Is it therefore vital that the midwife understands the importance of choice and is sufficiently prepared to adapt to change by having understanding of the influencing factors.

The Group is asked to:

a. identify changes which have affected the midwife and her practice in the last decade;
b. consider whether or not the present midwifery training enables the student midwife to learn to adapt to change;
c. suggest ways in which the student midwife throughout her training could be prepared for adapting to change. If training is not considered to be a suitable time in the interests of ensuring safe midwifery practice, how and when should the midwife be prepared?

a. Identification of change in the group had been varied. The members felt mechanisation had changed, and perhaps eroded, the midwife's role. Analgesia, particularly epidurals, had also brought about change.

The community midwife's role had altered considerably. The consumer was now demanding change. The group had identified the consumer's need to be involved in decision making, again changing the midwives' role. The group felt certain people had eroded the midwives' role, namely doctors, nursing auxiliaries and health visitors - and the attitudes of some consultant obstetricians.

The group said there was an increase of learners, but decrease in the profession's ability to retain staff. The shortage

of staff contributed to the changing role of the midwife.

b. The group felt the present midwifery training did not enable the students to learn to adapt to change. For example, on the use of monitors, there were some students learning only to care for mothers using monitors in labour and other students who never learned how to handle a monitor. It was suggested that hospitals and training schools should be linked to enable the midwives of tomorrow to keep abreast with research and medical advances.

c. A modular approach using objectives and evaluation was thought to be beneficial. This approach would help adaptation to change.

Finally the group members had themselves posed questions on this subject. They asked whether the management were encouraging this approach of adaptation to change. Were the management alert to the need for research and keeping themselves up to date? Did they evaluate the needs of their staff before sending them to sessions such as the one today?

GROUP SIX

Task: Continuing Education.

In order that the midwife might achieve her maximum potential, keep up to date, give informed opinions and make meaningful contributions within her profession, she must accept responsibility for her own continuing education.

a. Do the members of the Group agree with the above statement?
b. To what extent should self-learning methods be included in midwifery training?
c. Consider the resources which are required for the implementation or self-learning methods within basic midwifery training and available to the midwife for her continuing education.
Which of these resources should be provided by the National Health Service and which are available outside?

Generally the group thought the midwife should accept responsibility for her own continuing education, but whether she should accept full and complete responsibility was another issue. It was felt she should have the help of a person to provide guidelines and support.

The group thought basic general education was very important, and

basic nurse training.

One member of the group mentioned some midwives in Norfolk who met at intervals at one of their homes and discussed relevant information. This was thought a very good idea, a self-help group situation.

The group commented that hospitals had libraries with books, newspapers and journals, but very few people made the effort to read them. This led to the subject of motivation which was essential if people were to gain knowledge.

The group said there were now many relevant midwifery articles in newspapers. This had made some women more aware and questioning, although the more articulate women tended to be the ones attracted to such issues in the first place.

In the ward situation the group said the self-learning process could continue. It was unfortunate many student nurses and midwives felt guilty reading relevant books and notes when there was very little else to do. Also the student could ask questions of her senior - a continuous self-learning situation.

The group also discussed the problems of night staff and how they might miss available sources of information. When working ten to twelve hours a night, they were likely to be reluctant to attend meetings during their off-duty time. It was suggested that perhaps they should be paid to attend meetins in these circumstances.

In conclusion the group stated again that for continuing education to occur people must be motivated, and must be responsible for themselves

Miss Hickey closed the conference with a brief summary. There was a need to look into the future and be mindful of the views of those who were newly qualified or who had qualified within the last three to four years. The issues raised at the conference needed serious consideration and should be discussed in much greater depth with colleagues. Such discussion was necessary if a good service was to be given with good midwives trained in every aspect of the service. Mindful of some of the criticisms of this service she appealed to those actually at the bedside doing the work to help the management make decisions and form the future.

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