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## **A review of student midwives' conduct and support through supervision**

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## **Student midwives conduct and support through supervision**

### **Introduction**

Student midwives and nurses within universities sit within a very unique framework as they have the same rights and responsibilities as their peers studying in other disciplines however they are different (Karstadt, 2009). Nursing and midwifery students are enrolled on an education and training program that is preparing them to enter a profession which carries with it a high level of privilege and responsibility. Throughout the training of students they will receive information on what is acceptable conduct and behaviour and what the public expects from midwives. This is as well as being taught in university and assessed on the knowledge, skills and attitude that are necessary to become a midwife. All students although not registered by the Nursing and Midwifery Council (NMC) it is expected of them that they conduct themselves professionally at all times in order to justify the trust that the public places in the profession. To assist and provide clarity to students the NMC the UK regulator for nursing and midwifery whose function is to protect the public, have published in September 2009 guidance which sets out personal and professional conduct which is expected of nursing and midwifery students in order for them to become fit for practice (NMC,2009a). The university which they are affiliated with will also set out certain standards of conduct and behaviour that is expected. In addition to this as part of the education and training program student midwives are allocated a Supervisor of Midwives (SoM) with whom they can discuss issues which may arise in practice. The key role of the SoM is to protect the public and Warick (2007) states that this is best done by supporting midwives to deliver good quality midwifery care. It is envisaged that interaction between the student and the SoM at this early stage of their career will provide the student with a clear understanding of the role of supervision and the support which is available in midwifery practice by the SoM (Steele, 2009). The aim of this paper is to discuss the professional behaviour of student midwives and how supervision of midwifery can assist and enhance this process.

### **The beginnings – from when to where**

*“Midwifery is one of the oldest professions in the world”* (Graham, 1960 p ) existing from the beginning of time demonstrated by reference made to the Mother of creation by ancient civilisation and their relationship with the earth and other planets (Osborne, 2007). Osborne (2007) also refers to the area of giving birth as mainly referring to the woman as the “life giver” (p. 1.1) and the midwife as being “with

women” (p 1.1). With their knowledge of herbs midwives were often viewed as healers with mystical skills. The art and skills of midwifery were passed down from family members and through the process of apprenticeship of novice midwives to experienced midwives (Donnison, 1999). The professional regulation of midwives and hence the establishment of the Central Midwives Board occurred in 1902 following the attempt of eight bills proposing registration for midwives. The enacting of the Midwives Act in England and Wales established the requirement for training and the maintenance of a register this gave a monopoly of the use of the legal term midwife all of which Symon ( ) states are basic attributes of a profession. Today it is demonstrated in maternity services that midwives still have maintained a monopoly of services as Midwifery 2020 alludes to the fact that in childbirth some women may need a doctor but all women will need a midwife (Midwifery, 2020).

### **The professional status of midwifery**

The Nursing and Midwifery Council (2009a) states that students should be proud of the profession that they are being prepared to enter and should look forward to withholding the values and standards of the profession. Many students may embark on midwifery training and not consider the implications of what belonging to a profession actually entails and may be surrounded with a degree of confusion due to the lack of clarity and the inconsistent usage of the term professionalism. Also for many students appealing to their sense of duty does not work, they need to be given clear direction and will wish to know “why” they are doing something (Twenge, 2009) In the initial stages of training student midwives receive much information on what being a professional means and in particular what relates to midwifery. Symon (1996) refers to the debate which is still ongoing today on what constitutes a profession from the Marxists view which emphasises political power and economic dominance in a capitalist society and would give medicine as an example. Socialists from the Marxists persuasion state that a link exists between the power of professionals which contributes to social divide and cultural inequalities. For example Wiz (1992) examining the medical division of labour stated that medicine termed as “successful professionalism” originated from “class privileged males.” The Weberian view which relates to a legalised privileged group, who regulate the sale of their services based on societies needs and best interests. This group claims a more superior level of knowledge than the lay person and also demonstrates exclusivity by barring entry and competition from outsiders. Hughes (1994) in his definition of a profession refers to those who “profess” to know better than others what ails clients, and have the power to define what society needs and what needs are legitimate and worthy of their

care. Many of the above concepts mentioned such as power, control, male dominance and superior knowledge do not sit comfortably with the midwife who is empathetic and committed to working in partnership with women, giving women information and enabling her to decide on the care that is best for herself and her baby. Perhaps midwifery sits better within social science where professionalism is not viewed as static but is constantly changing as the needs of society change (Friedson, 2001; Sullivan, 2005; Hafferty, 2006). Several papers on professionalism refer to the social contract that professionals now have with society demonstrating the relationship which the professional has with society and what society expects from professionals (Symon, 1996; Sills, 1998; Cruess et al, 2010). Sills (1998) states that society grants prestige and autonomy to professionals in return for their services and if the professional does not meet their obligation to society, the contract will be broken and hence the professional status. This was demonstrated in the United Kingdom concerning medicine during the Shipman event when self regulation failed and led to a decrease in public trust and changes to the process of regulation (Secretary of State, 2007; Cruess et al, 2010). The community midwife is respected by families and society as an autonomous practitioner as Liaschenko and Peter (2004) state that professionalism being socially constructed views individual professionals as autonomous and distinct and in many cases distinct from the organisation they are employed by. Effective midwifery practice is about building up effective relationships with women and their families, meeting their needs on an individual basis and providing evidence based and safe care within a framework of clinical governance and self regulation (REF).

### **Characteristics of a profession**

The desired characteristics of a profession are referred to as having a unique body of knowledge, performing in a way which is altruistic or being motivated by helping others and for the benefit of others, having a code of ethics which regulates practice and working autonomously (Freidson, 1970; Maloney, 1986; Pyne, 1998). However differentiating for instance on what is termed as a profession and an occupation may be fraught with difficulty for instance does a hair dresser not have a unique body of knowledge and is well qualified in their field and attains to a professional standard, working in a manner that is thoughtful and responsible and thinking of the consequences of their actions. The hairdresser or those in occupations may work in a way which benefits others but not in a manner which benefits the client more than themselves. The hairdresser may advise the client to have her hair coloured when it doesn't really need done this would be in the interest of the hairdresser as there will be a monetary reward but will not be in the interest of the client. However you would not expect a surgeon to advise a

client to have surgery that is not necessary and that is not in the client's best interest. The professional should always have the interest of the client first and above that of their own basing the care they give on the best available evidence or best practice (NMC, 2008). Davies (2007) argues that a profession has elements that are not present in an occupation as of having a monopoly in the provision of professional services and having the right to self regulation. The process by which professions have a monopoly on services is referred to by Martimianakis et al (2009) as "boundary work" and marks the political attributes of professionalism where a professional group has the power to influence government policy by their expert knowledge, their regulatory status, education and their vitalness to the well being of society. This has been demonstrated where the status of obstetrics versus that of midwifery as in United States of America obstetrics has persuaded the public and Government that they are more capable than midwives in delivering maternity care and a result the role of the midwife has become that of obstetric nurse. The midwife in the United Kingdom is an autonomous practitioner stated by the NMC (2004) as being responsible and accountable within her sphere of practice to care for women throughout pregnancy, labour and in the postnatal period has by nature of this definition a monopoly of services to women in childbirth.

Midwifery as it has already been stated has a history of self regulation which is contained within the Nursing and Midwifery Order (2001). The Order requires the Nursing and Midwifery Council to set rules and standards for midwifery practice and also for the function of statutory supervision of midwives (NMC, 2004). There is also an onus on the regulator to police the performance of its members and to put the interest of the public above that of its own members (Davies, 2007). This was demonstrated within the Nursing and Midwifery Council by restructuring of its committees and the inclusion of 50% lay members in committees in 2008 following the report of The White paper Trust Assurance and Safety (2007). Symon (1996) argues that midwifery in the recent past did not fulfil the criteria of full professional status due to it being a female dominated occupation and coming from a feminist perspective which refers to professional groups as dominant and usually as being male. This "gender division of labour" Manley (1995 p. 980) states poses a hindrance to professional status for groups that are female dominated. Symon (1996) also referred back to the lack of autonomy in midwifery, obstetricians having a say in determining standards within midwifery services and the hierarchical structure within United Kingdom maternity units. To a large extent this has changed today as midwives

are heavily involved in midwifery and maternity services policy making and setting standards both regionally and nationally. Midwives have also increased their autonomy by pioneering and working in midwife led units across the four Countries in accordance with government policy. The NHS Plan (DH, 2000) and the National Service Framework for Children Young People and Maternity Services (DH, 2004) all promote the client centered approach and delivering care that is community based and is easily accessible to women. Maternity Matters document (2007) offers: choice, access and continuity of maternity care in a safe service (DH, 2007).

### **A Unique body of knowledge**

In defining what a professional is an extensive theoretical knowledge base is stated to be essential (Etzioni, 1969; Friedson, 1988). Midwifery education has undergone extensive change in recent years in terms of location, commissioning and accountability (Baird, 2007) It has “evolved from a model of informal apprenticeship” to standardised training within Higher Education Institutions (HEI) (Baird, 2007p. 400). The NMC (2007) endorsed degree education for midwifery as mandatory and there has been an increase in the number of pre-registration midwifery training courses throughout the United Kingdom. The introduction of direct entry midwifery education has provided a new dimension to midwifery where nurse training is no longer a prerequisite and has established nursing and midwifery as separate professions (Nixon and Power, 2007) . In a meta-analysis of 139 studies, Johnston (1988) found that graduate nurses perform better than non graduates in areas of communication, knowledge, problem solving, attainment of professional role and teaching others. University education provides exposure to theoretical knowledge and complex skills and it also provides professional power by controlling entry into the profession as a licence to practice can only be obtained by completing an accredited course of study (Yam, 2004). Nixon and Power (2007) state that control in education and changes in the form and structure of professional educational preparation programmes is significant and central to professional identity. Midwifery theory is essential for safe and effective practice as it challenges midwives to develop skills in critical thinking and to develop the ability and skill to discuss and debate research findings (Baird, 2007). Regarding linking the gap which may exist between practice and theory little is written regarding graduate midwifery education however the graduate status of nursing in relation to linking theory with practice has been referred to. Stating that graduates are perceived as lacking in confidence, have less job satisfaction and often experience negative reactions from colleagues and managers (House, 1975; Howard and Brooking, 1987). Mosley (2000) refers to a

study by Bircumshaw and Chapman (1988) which found that graduate nurses and midwives were less likely to practice within the medical model and were more likely to apply research findings in their practice. The art and craft of midwifery is viewed also as an essential component where the philosophy of midwifery is centred on normality and is based on the needs of the woman (Davies, 2007). Midwifery being practice and skilled based does not sit comfortably within the stipulations of professionalism that is referred to by Friedson (1988) as formal and empirical knowledge. Midwifery professionalism may be best described by Shaw (1993) when describing nursing practice as combining the art of caring with a pragmatic application to science. Schon (1987) describes two views of professional knowledge as the *technical rational* type referring to tasks being broken into component parts or skills and mastery of skills. Secondary referring to *professional artistry* which is concerned with not only with how a task is done but also what the end result is. Therefore it relates to conduct which is concerned with beliefs, attitudes, assumptions and values and not just with behaviour (Fish and Twin, 1997). De Cossart (2005) states that the artistry professional refers to the autonomous practitioner making their own decisions, using professional judgement and all within a moral code of ethics. **Need to put in theory practice gap done**

The supervisor of midwives is well situated as having a unique body of knowledge and is capable of performing as expert leader. Osborne (2007) states that "*for many supervisors their work places them firmly at the forefront as the providers of support and wisdom in a developing workforce*" p.555. Training for supervision of midwives is now provided by a number of higher education institutes (HEIs) and is studied at either degree or masters level producing a knowledgeable practitioner who is capable of assessing and analysing information, who is skilled in reflection and is assertive and articulate (Jones,2007). Warwick (2007) endorses that the supervisor of midwives must have vision, be able to articulate the vision, be a force for change and strive for resources and models of care that will accommodate women's choices and support and improve the environment in which midwives practice.

### **Altruistic service**

Traditionally the caring professions have been characterised by a self professed altruism, that is, a selfless service on behalf of or for others (Thompson, 1994).Altruism derived from the Latin *alteri huic* and focuses on being motivated to help others and wanting to do good without reward (Gormley ,1996). Health professionals in general are said to be attracted and recruited to the profession and are motivated by a desire of doing something useful and a desire to help others (Miers et al, 2006).

However there is evidence to suggest that extrinsic factors do play a part in reasons for entry to some professions such as occupational therapy where salary, regular hours and prestige are cited as a reason. (Rozier et al , 1992). Collings (1997) reported that those entering nurse training in contrast would display a lack of interest in financial gain or status. In a study of career choices in health care by Miers et al (2006) it was reported that student midwives tended to be more motivated to apply for training by the anticipation of professional rewards and because of their previous life experience rather than a commitment to altruistic service and the client group. Liaschenko and Peter (2004) warns that even though a desire is to provide an altruistic service to society is entrenched in health care professions we can focus too much on the needs of the profession and not enough on the needs of those we serve. She goes on to state that nurses can be diverted from their service to society by striving to be like physicians by taking on tasks normally performed by doctors. In many areas a comparison exists in midwifery where many midwives are striving to be like obstetricians taking on forceps deliveries and assisting at caesarean sections. When this occurs the question is raised who will be with women providing empathy, the therapeutic touch, information giving and the art and craft of normal midwifery. The automaton practitioner cannot always be free from the constraints of and responsibilities to others in the work place but must work both independently and collaboratively with others to ensure that all women receive safe and appropriate maternity care (Liaschenko and Peter, 2004)

Perhaps an apt definition for supervisors of midwives regarding altruistic service is the following *“Instinctive cooperative behavior that is detrimental or without reproductive benefit to the individual but that contributes to the survival of the group to which the individual belongs”* p21 (The American Heritage Science Dictionary, 2005). Supervisors of midwives have practiced unsalaried for many years and have only of recent times been awarded an allowance the amount which varies between local Supervising Authorities (LSAs). Also it has only been in the recent past that the NMC have urged LSAs to provide SoM with protected time for carrying out the supervisory role (NMC,2009b). not sure where this should sit

### **Autonomy in midwifery practice**

It is expected on qualification that midwives are autonomous practitioners will take on full responsibility for providing care to women during pregnancy labour and in the postnatal period (World Health Organisation, 1996). Mander and Fleming (2002) state, that it is the responsibility of Pre – registration providers of midwifery education to ensure that students are fit for professional practice at registration. Baird (2007) refers to the lack of literature relating to midwives and autonomy and suggests

that this may be due to the concept that midwives are generally viewed as autonomous practitioner. Hall (1968) classifies professional autonomy as two types - Attitudinal as being free to exercise judgment in decision making; Aggregate referring to legally granted self regulation and control of ones practice which is virtually not possible to achieve due to the involvement of government agencies (Dempster, 1994. Liaschenko and Peter (2004) refers to the difficulties which exist regarding the automaton practitioner and would question are they truly a professional. Liaschenko and Peter (2004) state that It is now impossible for a professional to be truly automaton and gives the area of medicine which would in the past unquestionably been viewed as profession but now most decisions affecting their practice are made at an organizational level and may not have localised input. Baird (2007) makes reference to the barriers which exist to autonomous practice for instance the medical dominance, working in a medical – led unit where midwives are unable to develop decision making skills, the existence of conflict between midwives and obstetricians as to the domain of normal and abnormal birth and the requirement of working within hospital policies and guidelines. In order to assist students to learn how to make autonomous decisions regarding normal childbirth the NMC (2009c) state that students should be actively involved in caring and supporting women giving birth in a number of various settings and have introduced the concept of caseload from the commencement of training rather than in the final year. Student midwives during training do have an elective component as part of the program and much could be gained in terms of autonomous practice in visiting countries where a social model of birth exists such as Holland Scandinavia and New Zealand (Baird, 2007). **Need to put something in her re autonomous role of SOM.**

### **The purpose of student guidance**

The Guidance on professional conduct for nursing and midwifery students sets out the personal and professional conduct that is expected of nursing and midwifery students in order to be fit for practice (NMC, 2009a). Guidance for students is based on strict standards set out in the professional code of conduct for registered nurses and midwives which is the foundation of good practice and the key to safeguarding the health and well being of the public (NMC,2008). The White Paper: Trust Assurance and Safety (2007) is a programme of reform to the United Kingdom's system for the regulation of health professionals. This was based on consultation from two reviews of professional regulation Good doctors, safer patients (DH, 2006)and The regulation of non-medical healthcare professions (DH,2006) and was complemented by the Governments responses to the recommendations of the Fifth Report of the

Shipman Inquiry, Ayling, Neale and Kerr/Haslam Inquiries (Department of Health,2007b). The White Paper : Trust Assurance and Safety (2007) issued guidance on how regulators should engage with students in training stating that education providers should encourage attitudes and behavior which constitutes professional conduct throughout pre-registration program's and students should be aware what is required of them from the outset of the course. They also suggest that students should be registered with the regulator at the commencement of training and subject to fitness to practice panels within the university if their conduct is in question. However not members of the public would view a code of conduct for student nurses and midwives as positive for example comments taken from the Guardian (2009) stated ha a code for student conduct was " Pernicious .... and destroying the distinction between professional and private life" or" like living in a big brother state where your thoughts and actions are monitored". Last year teachers unions objected to a code from the General Teaching Council in England stating that the Teaching Council had no right to control their personal life (REF)

The purpose of guidance on professional conduct for students is set out and professional conduct which is expected of students in order for them to be fit for practice, meaning that they have the skills, knowledge, good health and character to perform the role safely and effectively and are deemed worthy of entry to the register. Prior to this these decisions would have been made between the practice area and institutions using the code as guidance (NMC,2008).Karstadt (2009) states that he process will remain the same but that the new guidance will provide more clarity and transparency throughout the process. Baker (2009) promoted an exclusive code for students stating that it facilitates engagement at an early stage between the NMC and student rather than at registration and provides closer links between educational institutions, the regulator and employers. Not all individuals are happy regarding the NMC issuing guidance to students on professional ([how can the SOM assist here](#))

### **Good Character**

The Nursing and Midwifery Council in addition to good character before entrance to the register also require the Lead Midwife for Education to declare good character on entrance , continuum and on completion of all pre-registration midwifery programmes in the United Kingdom (NMC, 2009c) Sellman (2006) has questioned the concept of signing off students as being of good character by the Lead Midwife for Education. Sellman(2006) states that this is fraught with difficulties as it requires making value judgements about individuals in nursing and midwifery education and involves making assumptions on what constitutes good character. Good character will be assessed by the Nursing and

Midwifery Council on pre-registration midwifery training programs and depends on obtaining good character references and good character is approved if the student avoids problem behavior or a criminal offence, demonstrates that they intend to comply with the code and have not been suspended by another regulatory body (NMC,2008a 2009c). Sellman (2006) argues that this is an “impoverished account” (p.763) when a wealth of evidence exists within the literature as far back as Aristotle to what constitutes good character. Good character is based on attributes such as compassion, trustworthiness and commitment, our behavior, the situation we are in and possessing appropriate skills to do the job (Aristotle, 1953; Kant,1956; Harmann, 1999; Kupperman,2001; Sellman, 2006). Sellman (2006) warns against the confusion which can exist between those who possess the caring attributes of the good practitioner but do not possess the skills to perform the role safely and effectively. “Nice but Lethal” (ref). Sellman (2006) state that nurse and midwifery educationalists must do more than teach cognitive and motor skills but must include moral attributes which will ensure confidence when declaring that the students is of good character Begley (2005) describes three attributes as pertaining to good character, *intellectual* which refers to theory and practical wisdom or having the knowledge and skills to do the job; *Dispositional*<sup>1</sup> refers to possessing attributes such as compassion and courtesy and finally *Moral* attributes such as justice courage and veracity (need to expand on these slightly)

### **The personal life of students counts**

The question arises do nursing and midwifery students need to be reminded of behaving appropriately both on and off duty (Baker, 2009) Karsdadt (2009) states that students working in clinical practice and being taught in the class room know how to behave as it is emphasised regularly by tutors and mentors. It is important that students are aware that their behavior both during their programme and in their personal lives has the potential to have an impact on their fitness to practice, the potential to complete the programme and the willingness of the university to sign the declaration of good health and good character (Lloyd,2009). Students do have a duty to report to the university if they have been cautioned, charged or found guilty of a criminal offence at any time before or during their programme. Examples of areas of concern would be aggressive behavior, dishonesty, drug or alcohol abuse or health concerns which may impact on their fitness to practice (NMC, 2009a). Students need to interpret and apply student guidance in their own practice as in many cases the public do not view students as any different

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from registrants and expect the same standards of professional behavior. Maintaining confidentiality can sometimes be problematic as outside of work a student could easily drop the name of a client within earshot of someone who may know the person. Karstadt (2009) states that this can be due to inexperience or poor judgment on the part of the student and the guidance provides them with an opportunity to discuss the situation and learn from their mistakes. The student guidance (2009a) is very clear on areas such as maintaining clear professional boundaries which means not accepting gifts, hospitality or favors from clients which might be interpreted as an attempt to gain preferential treatment. The fourth principle of the student code states “be open and honest, act with integrity and uphold the reputation of your profession” (p11). Karstadt (2009) academic misconduct involving cheating, forging signatures on assessment documentation, plagiarism and non attendance at lectures without a valid reason is considered as dishonest. This is not uncommon in universities and can be significant enough to indicate that an individual is unfit to practice (Karstadt, 2009). Karstadt (2009) further endorses that the behaviors previously mentioned are not what is to be expected from a soon to become registrant. The Press reported in the recent past regarding a student midwife who gained unauthorized access to computer records in her placement area and falsified her EU Directive records in order to meet the required standards for registration. This student was on the shortened midwifery program and was already registered as a nurse so therefore was expected to practice within the Code of professional conduct: standards for conduct performance and ethics (2008a) and this led to her being removed from the register and being jailed for six months (Daily Echo, 2007). Roughley (2007) argues that student midwives are under extreme pressure in order to achieve their clinical competencies however student midwives are expected to control their own learning and to a certain degree determine their clinical and academic needs, seeking support from personal tutors and mentors when difficulties arise.

### **Social Networking: care must be taken seriously**

The NMC guidance on professional conduct for nursing and midwifery students (2009a) states that clients should be treated as individuals and their dignity respected, their right to confidentiality should be maintained and students should uphold the standards of the profession at all times. Students must be aware regarding social networking that any discussions they have online may end up in the public domain and could be read by employers or by clients (NMC, 2009d). Comments that may cause offence

to clients or colleagues should not be posted on the network. Making disclosures regarding clinical practice could cause a breach of confidentiality and compromise fitness to practice. This also goes for perhaps innocently taking pictures in the clinical area where clients can be identified in the background and is causing a breach to their privacy (Lloyd, 2009). Students should be aware that posting explicit pictures of their person on line could not only damage their reputation but may be damaging to public confidence who may question the student's ability to give them care (Lloyd, 2009).

Perhaps include a section here on how som can help support students using the package we developed for the SHSCT

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## SUPERVISION OF MIDWIVES AND STUDENTS.

Student midwives become qualified and registered once they have successfully completed an approved midwifery course (NMC 2004). During their course they are supported, guided, and assessed in their learning in clinical practice and in the Higher Education Institution (HEI) by midwife mentors, practice-teachers, and midwife teachers, whilst a host of other members of the maternity services and educationalists contribute to student learning. The NMC (2008) set clear standards as to the means by which a midwife becomes a mentor, practice-teacher or midwife teacher and how a student midwife

should be supported throughout the period of their midwifery course. Such support facilitates the transmission of knowledge, skill, attitudes and attributes from one generation of midwives to the next, aiding learning in an effective and efficient way so that care to women can be provided by knowledgeable, compassionate practitioners that match the professional expectations required.

At the point of registration, and in order to practice, each midwife is appointed a Supervisor of Midwives (NMC 2004) whose role is to provide continuous, professional support to enable safe and effective midwifery practice, thereby ensuring women and their families are the recipients of good, evidence-based and sensitive care. Since the aims of both mentoring support and supervisory support are similar, the question arises - does the Supervisor of Midwives have a role that benefits the student midwife?

Although student midwives are not specifically mentioned in the NMC (2006) Standards for the Preparation and Practice of Supervisors of Midwives, a closer look at the 'Midwives rules and standards' (NMC 2004), rule 12 shows that the Nursing and Midwifery Council clearly link the two and expect the Local Supervising Authority (LSA) to

*'enable students to be supported by the supervisory framework'*

and in rule 16, the LSA will report to the NMC

*'evidence of engagement with higher education institutions in relation to supervisory input into midwifery education'.*

Also, the NMC standards for pre-registration midwifery education (NMC 2009) expect students to practice within 'The Code' (NMC 2008) and to develop their own self-development by engaging and utilizing the statutory supervisory framework. Statutory Supervision of midwifery certainly has a place in the development of new midwives and student midwives to nurture that fresh approach and enthusiasm they bring to their embryonic career (Kitson-Reynolds, 2005). Indeed Mc Kenzie (2009) noted that, without exception, all the LSA's had been able to report to the NMC a diversity of means by which supervision of midwifery worked with midwifery academia and practice to support and improve the learning experiences of student midwives across the UK. However, Kitson-Reynolds (2005) claims that SOM is misunderstood and underutilized when it comes to student midwives, hence this article will explore the direct and indirect relationship between supervision of midwives, midwifery education and student midwives.

## BEHIND THE SCENES

One reason that the role of supervision of midwifery can be clouded to the learning student is that much of the work occurs 'behind the scenes'. The SOM is responsible for creating an environment that cultivates safe and acceptable care for women and their families whilst fostering the development of midwifery practice at a generic and personal level (NMC, 2006). Some aspects of the supervisory role is

background work that underpins 'coal face' practice, for instance, policy and procedure development, clinical governance, clinical and supervisory audits, directly contributing to supervised practice, and providing individual annual reviews. Furthermore, SOM's may also be performing some of these duties in a dual role, such as ward manager, practice development midwife, and, some supervisory duties, such as administrative work, are invisible to the student midwife.

Secondly, supervisors of midwives work with various approaches, some having more clinical visibility and direct client and midwife contact than others (Halksworth et al, 2000), for instance, some will be midwife teachers or midwife managers and SOMs whilst others will be midwives working directly with woman and families.

To promote the role and activities of the SOM, it could be made clear to one and all when a SOM is acting as such, and a simple remedy is to communicate directly her role and/ or to add her supervisory title to any correspondence/ professional signatures to such work. Given that student midwives access protocols and policy documents throughout their course, they should then be able to identify supervisory involvement. Since women and families should easily be able to contact a SOM in her area (NMC 2009), the same information should be available to student midwives and clinical areas are known to use information leaflets, websites or notice-boards to advertise the contact details of SOMs.

#### PROFESSIONAL VISIONARIES

Supervisors of midwives are, on the other hand, appointed to be professional leaders and visionaries, and Warwick (2007) notes that qualities such as upholding professional values, visibility (being seen at the coal face) and optimism can steer the profession into the future, the strength of supervision is of being based in regulation, not employment (Warwick, 2009). A high level of midwifery supervision visibility is important, for instance, in the development of 'Midwifery 2020' and the review of the NMC (2004) Midwives Rules, to ensure that the profession remains focused on the needs of women and that as a profession, midwifery is being best equipped to deal with their needs.

To achieve this SOMs need to be the transformational leaders described by Daft (2002) who have a strong sense of vision for the profession, who can communicate the need for changes within the profession and motivate others to believe in the need for change and to develop and empower midwives into future leaders.

Students should be able to clearly see where midwifery stands within society and within health services, and take confidence in the fact that the midwifery profession, in conjunction with women, are deciding and directing it's future. The midwifery profession can socialize students into a profession that is equipped for the future, without quenching the creativity and individuality that new recruits can bring.

*In order to succeed, however, SOMs have to overcome and prevent the barriers of learned helplessness that occurs with powerlessness, authoritative and controlling hierarchal organizations and patriarchal dominance that Maresh (1986) claims to suppress professionalism, rather SoM's can empower midwives who can, in turn, empower women.*

#### DIRECT CONTACT WITH EDUCATION PROVIDERS

A more direct example of how supervision directly impacts midwifery education is the collaboration that occurs between supervision and midwifery educational institutions. LSAMO's forum (2009) has set a strategic goal to be involved with curriculum development, validation and quality assurance events of midwifery education. Having SOM involvement in such work ensures that there is freedom within the curriculum for development of accountability that will prepare midwives for registration and ensure that evidence based practice remains at the forefront of midwifery education. This involvement includes pre- and post-registration education. A reassuring report from the LSA's (NMC 2008) comments that all LSA's can 'robustly' meet the requirements of rule 16 (NMC 2004) and show evidence of engagement with HEI's to ensure evidence based practice.

A further strategic goal of the LSAMO forum (2009) is, using such collaboration with HEIs to ensure that students are exposed to the positive benefits of supervision. This can be done both in tuition and in practice where the role and responsibilities of the SOM can be explained and students can witness and be involved in active or theoretical case supervision activities.

Supervisors also have a responsibility to ensure standards for education and practice are met in the clinical environment (Steele, 2009). This has the advantage of benefiting the whole organization, not just the student midwives. Any concerns about practice conditions in the clinical learning environment that may adversely affect student learning should be reported to the NMC, particularly if those concerns are in relation to the learning environment and ability of mentors to support students. If students are facing difficulties in clinical practice, this may be reflective of the general work ethic and approach and could, potentially, have a detrimental effect on woman and families. Finally, the LSAMO audit clinical placements and the student and user perspective is reflected in these audits for the (LSAMO 2009, NMC 2008). So supervision of midwifery is concerned that the student experience is positive.

#### DIRECT CONTACT WITH STUDENTS/ MENTORS

Is there then any need for direct contact between a student midwife and an SOM? Students rely on mentors to develop self-confidence, and development of competence is a career-long event (Steele, 2009) and hence there is a strong support mechanism in place for student midwives. The NMC (2004) Midwives Rules, however, say that students should be 'supported by the supervisory framework', and, for a student to be fully conversant with supervision of midwifery and to be prepared to be supervised on the point of registration it would seem sensible that the student has some direct access to a supervisor of midwives. Early introduction of the students to the foundational principles of supervision

and, if possible, introduction to a SOM enables a developing relationship to form and enables students to understand the role and thereby be proactive in its use (Steele, 2009). On the other hand, it is not known what it is that students expect from supervision that is over and above the support provided by midwife mentors and midwife teachers.

Licquirish and Seibold (2008) found that student midwives appreciated being mentored by midwives who are caring and supportive, willing to share knowledge, fair in assessment, have an ability to reflect or debrief on practice and offer a woman-centred approach to care. These qualities are also reflected in good supervision of midwifery (NMC 2006). Nevertheless, mentors are well placed to provide this support, with a good working relationship and good appreciation of local issues. SOMs, on the other hand, can also be a positive professional role models for students to emulate.

Student midwives can be faced with difficult practice situations, which, indeed can be excellent learning situations if addressed in a supportive way. Difficult situations, though, can invoke anxiety, and anxiety interferes with learning (Chamberlain, 1997), but timely support from an SOM can reduce uncertainty and apprehension during occasions such as complaints or tricky practice issues (Mc Guinness, 2006). Indeed junior midwives sometimes need direct help from SOMs in unusual cases (Gnash, 2009) and by showing the student that the SOM is a valuable mechanism for advice and guidance, students can learn the benefits of access. Whilst involvement of an SOM can blur issues and there is the danger of overlap with mentor/teacher and the potential for conflicting advice, they might be able to offer a more objective perspective that advocates on behalf of woman, she can be another voice to add to any debate, and she can focus specifically on practice issues rather than institutional or educational issues.

Students can also experience a 'theory –practice gap' and do not always experience midwives who are inherently confident and accountable in making decisions and basing care on best evidence available (Fowler, 2008). The SOM can be a practice- advisor/ guide through difficult circumstances which can be addressed locally by guided reflective thinking. In addition, the SOM is also well placed to challenge practices that are out-dated, and students have been shown to welcome such support (NMC 2005). SOMs can be directly involved in developing the environment that facilitates reflective midwifery decision-making, asking prudent questions and handling the 'situation' rather than the individuals (Ralston, 2005). The SOM can be the positive role model showing behaviours and knowledge considered optimal for the role of midwife- bringing midwives to the stage of being able to move appropriately within and outwith policies and protocols (Fowler, 2008).

On the other hand, mentors sometimes experience anxiety and stress when assessing a student who is not meeting her learning outcomes and mentors find it particularly difficult to fail students (Fowler, 2008), and the SOM can offer support and, again, an objective and professional practice- based perspective during such events. Conversely, it should also be remembered that students have a

professional responsibility to ensure they receive appropriate mentoring and take appropriate action when it falls below standards (Hassell, 2008)

The NMC (2008) report that some students are being individually allocated to a SOM, whilst others experience group/ cohort allocation so there is clear evidence that students are being supported by the supervisory framework, however this, for the SOM, is in addition to a supervisory caseload and has workload implications for the SOM. Supervision drop-in clinics are an efficient, practical means of meeting with students- ensuring their needs are met (Kitson-Reynolds, 2005). It does, though, require the SOM to facilitate and enable this (Kitson- Reynolds, 2005).

#### FINAL DISCUSSION

Student midwives are well supported throughout their midwifery education with a range of specifically tailored means of support. There is potential for overlap and overkill for students and SOM alike and time is non-elastic but efforts into some areas will reduce time needed in others. The earlier a student understands the role of the SOM, the sooner she can utilize supervision to her professional benefit and the better equipped she is to positively engage with supervision of midwifery.

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