HOT TOPIC: Support and Supervision for Midwives and Student Midwives

by Gill Jackman

Equality is at the forefront of many of our aims these days. The idea is enshrined in codes of practice and equal opportunities policies. Equality is what many of us are striving towards. Whereas in the old days making sure that our clients or patients had informed choice was something we did on the quiet; something we had to 'get away with', now it is legitimate. Written down as policy and taught to us in the classroom, it is the theory that underpins the practice. Unfortunately that does not mean that providing equality is easy to do. In fact it is very difficult and so necessitates a degree of understanding and a code of practice not so much tagged on the end of our midwifery training as theory, but running through everything we learn like the word Brighton through a stick of rock.

Why, you may be asking, have I begun an article about supervision and support by writing about the equal opportunities policy? A very good question. For many of us, this policy is one of many covered separately from more important things and we still view it this way despite the efforts of many training establishments to embed all of our practice in it. The short answer is because you can't have one without the other.

If client centred care is really what we believe is right; if handing power and decision making over to the patient is our aim we have to learn:

a. the skill of communicating information

b. the capacity to allow people to express and explore their lack of confidence

c. the ability to retain our faith that they can find what suits them

d. the confidence to facilitate others to make sometimes difficult decisions.

Is this process at the heart of client centred care? I anticipate many searching questions arising from this definition; many 'yes buts'. 'Yes but. within reason'. 'Yes but..not if the baby or mother is at risk'. These are hugely important questions. Unless they are explored by midwives so that

they can reach their own conclusions they remain vague concepts: 'within reason' or 'at risk'. They beg the questions 'what is reasonable?' 'what is risk?' Eventually we fall back on received wisdom for our answers- often the received wisdom of the medical model - unless we have a chance to really examine our thoughts, feelings and experience in a very wide variety of situations. Putting aside the 'yes buts' for a moment, I ask again, is the process outlined above at the heart of client centred care? If the answer is yes, the next question has to be how do we implement this process with skill, with safety and with confidence in our own judgement?

Isn't this the same question that all our mothers-to-be are asking regading how to be a good parent? Well, perhaps that is a bit idealistic, but no more idealistic than the notion that this is the same question that all midwives are asking themselves! We are not all the same, we don't think in the same way and we are not all as overtly conscientious as the next person. But it's what we all want. Not only that but it's enshrined in policy. So let's assume that the mothers are trying to do the best for the baby and the midwives are trying to do the best for the mothers and that 'best' is defined, within policy as 'women-centred'.

As midwives in our relationships with mothers we are always asking them, 'What are your concerns' 'how are you going to achieve your aim?' and giving them lots of appropriate information to help them. We hope that they will open up to us so we can clear concerns out of the way, so they can see the best way for them to manage this new parental experience. They think about what they are doing, they gain confidence, they follow their own lights.

This is women centred care.

Midwives might be doing a different task because clearly they are not giving birth, but they need the same process of support.

As a supervisor in my relationship with supervisees I am always asking them, 'how are you going to do it?' 'What are your concerns' and giving them lots of appropriate information to help them. I hope that they will open up to me so we can clear concerns out of the way, so they can see the best way for them to help each woman manage this process. They think about what they are doing, they gain confidence, they follow their own lights.

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This is midwife centred supervision.

What I am suggesting is that a radical model of supervision closely mirrors the skills used at the heart of women-centred care, skills that need to be modelled at every level of the maternity services if we are genuinely going to provide women-centred care and not just pay lip service to it. This model is perhaps the only way to implement real equality of access to services, information, and choice because to really be equal we need more than hard knowledge; we need confidence in our own judgement. My sister is a teacher and came late to teaching. One of the more amusing aspects of her training involved being lectured for an hour on how teachers shouldn't just lecture for an hour because it doesn't teach the students anything. To some extent this is what happens to student midwives when they learn about equal opportunities. Telling, rather than showing, is cognitive and eventually can become a dogma—a set of static ideas. Showing goes beyond ideas and into the experiential realm and this is where the deep knowing of the midwife comes from. Ask any group of midwifery students and their own experiences of birth and what might have helped them will be at the forefront of the mode of practice they adopt, build on and modify.

All is not well in the state of midwifery today. !0 000 midwives short and not enough skilled and qualified midwives to supervise and train new students. Midwives are leaving the profession in droves because of money, low status and lack of support. Maternity services within the NHS resemble a sink without a plug in it. Everyone knows that money is pouring down it and most disillusioned midwives would agree that enough of their energy has drained away too. There is however, new and pioneering work in the field of women-centred care where midwives are returning to work, but this is rare. It is my aim in this article to cover the first stage of a metaphorical labour for this 'hot topic' by analysing the fundamental conflict between women-centred care and the deeply entrenched and often unconscious beliefs and attitudes within the NHS. This part I shall call How did we get in this mess? I believe that unless these are picked apart and rightly challenged, the practical real changes necessary to implement policy will never become properly embedded but will continue to fall on stony ground. That is not to say that we all have to become academics. Far from it. The good news is that understanding theory is not even necessary to effect change, the only understanding we need is of ourselves. What is necessary is the supportive space to reflect, build on and be encouraged in feeding that deep knowing which is perhaps the source of the midwives' vocation. This is

called supervision, the structure and aims of which I shall cover under the mirror image sub-heading: How do we get out of this mess?

How did we get in this mess?

We work within a system where the medical model is at odds with the woman-centred approach to midwifery. I personally don't think it has to be but research shows that currently, it is. Mostly people delivering babies in the NHS are too busy to really engage theoretically with why, but the moment risk enters the equation both outside and inside the hospital environment is the moment when the practising midwife comes up against the conflict and she knows it. The medical model recommends physical intervention; the woman-centred midwife recommends staying with the natural process. One is a 'thing' you can do (forceps/epidurals/monitors) but the other is a process and so much more difficult to get hold of. Does that make it of less importance to giving birth?

The midwife has many skills that are difficult to quantify, is probably deeply intuitive and understands the place of trust in what is a unique experience for every woman. She cannot be sure of the outcome. By a series of minute checks, of signs and signals that relate to one another she grasps the situation and assesses the risk to mother and baby. She could spell them out if asked but she hasn't got time! Perhaps she's not even fully aware of how she works but if anything goes wrong, then spell them out she must. If she can't she's in serious trouble. The strictly medical practitioner, by contrast, gets to do 'things' and he/she is a lot more sure of the outcome. What she/he is doing is far more measurable every step of the way because it is not a process, intimately linked with every other aspect (the woman's emotional state being one of them) but a defined and much smaller, procedure, with a clear beginning and a clear end.

Let's face it, whatever you think of it, the culture we live in is never going to let us do anything, process or procedure, without accountability. Is accountability such a bad thing? Of course not but being accountable for a less understood process is never going to be as easy as being accountable for a medical procedure. Particularly when accurate measurement and complete control are deemed to be the apex of our aims. And here is the real heart of the conflict. This notion of 'complete control' is in direct opposition to what we are doing as midwives, Sometimes we seem stuck with a language that doesn't fit our profession at all - frequently handed

down from a select committee. Our policy says our aim is to hand control to women. “She should be able to feel that she is in control of what’s happening to her.” This is rather ironic when what every practising midwife knows is that at the core of this process is the most profound experience of being out of control that a woman has ever had. No wonder we’re in a mess when the concepts we use to even discuss our aims don’t fit with the experience.

This then, is a good way of identifying where we are going wrong. There is process and procedure. Complete control or close to it, is a concept that fits with procedure. It suits it. It is an integral part of that principle which informs the medical model.

The mistake that has been made is there is no recognition that the concept of control does not inform the woman-centred process and using it as a conceptual tool to improve our women-centred skills is confusing because it does not fit. Control is part of the medical model. And that’s fantastic. If I needed a caesarean, a controlled medical procedure would be absolutely appropriate and I would be very grateful for it. However, using the concept of control, whether the midwife’s control or the mothers, within the process of natural labour, is not appropriate. The words we need and which don’t get their rightful status, are facilitating choice.

So we have two very different types of skill and they are characterised in different ways because they are different, and embody different principles:

The caring principle reaches out to reassure, to soothe, to calm, to inform at an appropriate level for that woman; to instil confidence. If this is done expertly and continuously, the level of empowerment that is right for the woman, given the circumstances, will be the natural outcome. By a process of accompanying suffering while being simultaneously able to accept and empathise with it, the midwife enables the mother to tolerate the transition via an awesome process into an awesome new role in her life. Mystery lies at the very heart of birth and I doubt if anyone would argue with that. Our power should lie not in understanding or controlling the mystery but in accepting it and facilitating it.

The measurable, informed and scientifically based principle is much less mysterious and more straightforward. Very few people would argue that if a woman’s pelvic cavity is too small for a babies head, she should just trust that everything will turn out healthy. Equally, if a woman is in labour but

not contracting or if the placenta prevents the babies birth we know controlled intervention is crucial to health of both mother and baby.

So why are these two models in conflict when it is so obvious that they should be side by side, ready to provide the type of care needed? In order to clarify I am going to refer to these principles by their classical name. The first I shall call the feminine principle and the second I shall call the masculine principle.

The feminine principle is undervalued and subordinate in our culture and this limits our capacity to have confidence in and build on it ourselves. If we are empathic, open and tuned in creatures then it follows that in order to nourish this principle we need connection and support ourselves. The instant experience of shame within our culture at acknowledging this need just goes to show how far out of balance we have become and how far we have gone along the path of embracing the masculine principle as more important: 'I'm independent', 'I can manage'. As a consequence, support is seen to be dispensible; optional rather than absolutely necessary. If it were seen as absolutely necessary, needing it would be nothing to be ashamed of. This imbalance has occurred because what is deemed more important in our culture is the masculine principle, so much so that we have swallowed many of the values of the masculine principle and discarded many of the feminine without even realising it.

As a result the feminine, caring principle has become embedded in the masculine, controlling principle, so much so, that even the word 'control' has seeped into it: The masculine principle has appropriated the feminine principle. The 'care' is tagged on, seen to be less important so that the system of maternity care has been turned upsidedown. Instead of medical procedures being a part of the midwives and women's maternity services, available as a consort or there to help when we decide that more than trust and facilitation is needed or when we decide that controlled procedure is needed, women-centred care has become part of the medical model's maternity services. We are allowed to do it our way but when the chips are down and all this indefinable supportive wishy-washy stuff might look a bit dangerous, it will swoop in and do the real business.

But when are the chips down? That, is the central question. Remember the mantra of our profession: 'all practice must be evidence based.' Despite appearances to the contrary, we do have evidence for the less definable aspects of our work, but we are rarely given the confidence to present and

build on it, and I'm not just talking about research papers. Assessment and measurement of risk is something we do all the time. All we need is the space to reflect and become aware of how and why we made the decisions we made. This space is at the heart of the supervision model I shall go on to describe. This model builds confidence as well as accountability and this way, we can not only be heard but we can challenge some of the medical decisions on an equal playing field.

The dominant value system, that of the medical model, cuts in and takes over when doubt arises as to what is in the best interests of mother and baby. And this is sometimes extremely difficult to judge. When this happens in practice, instead of equal parity being given to both principles, the medical model takes precedent, and unless we are fully confident and feel supported and growing in our practice of the feminine model, our doubts undermine us and we go for the apparently 'safe' option: controlled procedure. This is how the medical model has taken over us. It lurks in our psyche, ready to take the safer option often before it really should. This dominance is reflected right through the maternity services. How much money goes into concrete machinery and how much into time allocated to develop and support how to care, how to deepen intuition, how to build confidence in it? Ultimately this goes back to which principle is more highly valued. If we knew, without a doubt, that the medical model was always better then making the caring skills subordinate to the medical procedures would be a relatively obvious option but research has shown that no options are risk free. Not only do caesareans carry long term risks to the mother because of standard complications associated with major surgery but they weaken the uterus and surrounding tissue, and often create problems bonding with the baby. Monitoring, which on the surface looks wholly good because one can assess measurable risks as they occur, has proved conclusively to be part of the problem as much as it is part of the solution. It frequently leads directly to increased intervention, snowballing from electric monitoring to distress for the mother to drugs, epidurals, vontueses and ultimately caesarians. Everything that happens in the woman's environment is intimately connected to everything else. And this includes her panic and ability to tolerate pain.

This new type of research poses a major challenge to the older 'scientific' and measurable viewpoints. There is increasing evidence that health is holistic and about far more than defining and separating systems of the body and mind from one another. The fairly recent developments to include

and legitimise qualitative research in research based practise and to include women's experience, feelings and beliefs as a valid criteria directly challenges the old 'bodies as objects' notion, generally perceived up until now as 'real science'. Because we are dealing with people, 'hard science' is increasingly recognised as having a much smaller (although still absolutely necessary) part to play in maternity services, whereas 'social science' acknowledges variables outside of the strictly medial paradigm or framework of what is considered relevant. Though there is a lot of new qualitative research, there is also new quantitative research. What has changed here is not so much the method as the hypothesis, the question being researched. For instance, instead of asking 'does a caesarean get a baby out with less risk to its head?' increasingly it asks 'does a caesarean restrict the mother's flexibility in relation to the baby once it is born?' If we are looking at whole health as an aim, a slightly squashed head might be less damaging than a mother who can't pick the baby up at all for 4 weeks.

Perhaps it is becoming clearer that contrary to popular belief, science, rather than being wholly objective, is underpinned by very subjective interests. Our value system deems what is important and then seeks to determine what we study. It is no surprise that as women have gained more economic power and independence, their value base has come more to the forefront and commanded more respect. This, I think, is what we are now increasingly fighting to develop and sustain.

(It would be easy at this point to make the mistake of confusing women-centred care with non-interventionist home-birth, and while there is growing evidence that if a woman feels supported she'll often opt for non-intervention, I would like to clarify that freedom of choice ultimately includes the freedom to choose a caesarean section. What matters in this article is not what choices women make but whether or not they feel supported and objectively given accurate evidence to make the right choice for them. It might be that a woman's choice is not to make a choice - it might be that her relationship with you as her midwife is so trusting that she hands all the decision making to you. It doesn't mean she's not empowered. It might mean that she's not as empowered as we'd like her to be but that's our problem, not hers.)

When we talk about values we are expressing an opinion about what is important, from which our beliefs develop, which we constantly, if unconsciously test as valid or not valid. Every time as midwives we are

empathic and soothing and we witness a woman relaxing or accepting her pain this is what we are doing. From our experience of this working or not working we monitor and redefine not only our practice but our ethical and moral framework. If we can articulate how we do this we can reflect, expand on and legitimate the feminine principle, bring it into parity with the medical model and, most important for credibility, we can be accountable, increase our confidence and challenge what is going on in the wards.

Carol Gilligan's in depth work on different value bases goes a long way towards showing why we often end up in conflict. What Gilligan discovered, from thousands of interviews was that men and women are fundamentally different in terms of what they consider important. Generally speaking, men are abstract and analytical, breaking things down into component parts. They are most concerned with what is fair, rather than what is human. This Gilligan defined as an ethic of justice. Women see the needs of the whole rather than the part, are concrete and specific about what is happening to people and their current experience and are most concerned about relating and whether people are unnecessarily suffering. This she defined as an ethic of care.

This fits with the new language we are all familiar with: 'men can't multi-task', 'women can't analyse without getting emotional'. This is a real hot topic! And unless we take extreme care in our discussion of it we go down the route of stereotyping. Although these are Gilligan's findings, I hope to avoid accusations of stereotyping by referring to my previous classical labels. Let's just say that there are two different value bases embodied in the masculine and feminine principle. We all carry the capacity to implement both, therefore when a midwife begins to impose control, she is implementing the 'masculine' principle, and whenever the obstetrician is facilitating empowerment she is implementing the 'feminine' principle. As I said before, there is an appropriate place for both, but we need to be able to see what they really are if we are honestly going to give the 'feminine principle' which I would say here is women-centred care, the parity it deserves. I would also accept that there are often tendencies in women and men to find some things easier to do that others. Everyone is most confident in what they know how to do best. That is not to say, however, that they can't gain confidence in many areas they have not been brought up to be confident in. What is great about this is that they bring to their new area an expertness from their old area which can enrich. I might be writing an

academic analytical article about supervision but I am adding new data to analyse that the medical model doesn't include. And I am bringing my value base. This brings in the possibility of a cross-fertilisation of the two principles.

What I am saying is logical, consistent and backed by research. It involves harnessing the masculine principle to make my point, but how else am I to do it in a culture which rates control, reason and accountability way above the capacity to empathise? What is important is raising the profile, value and resources given to women-centred midwives. This way the feminine principle can be given the space it needs to take its place alongside rather than subordinate to, the masculine principle of control and measurement.

I believe it is easy to underestimate what we are up against here. I may understand it. I have certainly tried to explain it but ultimately what we are talking about is an imbalance of power and history has shown that power is not given up, it has to be wrestled away and that, I think, is why so many of us experience our working life as not unlike a war zone. Traditionally women rarely fight. They go underground and are picked off one at a time as they lift their head above the parapet. In seeking to get an unacceptable level of control the masculine principle has spiralled out of control. The fear generated by this leads to great resistance: what is not fully understood is feared, especially if it is powerful. Arguably there is nothing more powerful in the world than a woman giving birth! How, against such odds in such a climate of fear, are we to feed the feminine principle so that the natural process of birth can take its rightful place since most often, evidence shows, it is the safest option for mother and baby?

How Do We Get Out Of This Mess?

I would argue that it is surprisingly simple. All that really needs to happen is that our cares and concerns must be addressed in order for what is a natural process to not become blocked. As midwives present through a woman's birth process, this is what we aim to do for her, but if our own fears get in the way, we may bring in control too soon because we feel 'out of our depth' and sometimes we fear being sued as well as abandoned by our professional bodies. In such a climate how can we gain confidence and experience in our own judgement?

I believe that the statutory caring professions can learn a great deal from the person-centred model of counselling supervision because it embodies the feminine principle we have discussed while maintaining the aims of protecting the client against bad practice. This model integrates both support and supervision. If the masculine principle is used, what you get is control and specific measurement. From the point of view of many midwives, the concern about supervision is: 'How can I really express how I feel when I know that the person I am talking to is scrutinising me and ultimately making a judgement about my competence to practice?' Using the feminine principle the supervisor is not so much 'scrutinising' as facilitating reflection and challenging the midwife to go deeper. As for making a judgement about competence to practice, midwifery is a huge responsibility and midwives know this. If they don't, the challenges and questions posed by the properly trained supervisor will mean that they have to reflect on it. Given the right space and conditions, they will reach a decision about their own limitations way before the supervisor does, in the same way as the woman giving birth will gain heart and confidence through our deep empathy and make a decision about her own limits and abilities.

Briefly, the how of person centred supervision entails:

a. *Holding rigid boundaries of time and non-interruptible space. In counselling these are none-negotiable. If a supervisee does not attend one and a half hours supervision a month they are not meeting the (soon to be legal) requirements to practise.*

b. *In counselling there is no hierarchy of knowing. Only of knowledge and experience. I am not all seeing into another person's competence, though I may have concerns and it is my responsibility to make sure they are addressed. We are all equal in terms of our need for reflection and support. These things give us the energy we need. No one, however 'expert' is immune to this.*

c. *Core conditions are: Unconditional positive regard for the supervisee; Empathy for the supervisee; Congruence as a supervisor about the aims and concerns we are addressing. Pysychological contact with the supervisee. All of these conditions have to be present if the supervision is to do its job.*

d. *Allowing and exploring all the 'yes buts' in order to take them seriously and relate to where our trust in the natural process becomes compromised. These will change as the supervisee grows in experience.*

One of the most useful ways of conceptualising this radical model of supervision is defined by David Mearns and Brian Thorne in their book, Person Centred Therapy. They highlight how using a deficit model when we work with people elicits a very different outcome to the outcome we get when we use a potential model. As a supervisor, if I am only looking at what my supervisees are not doing or could be doing better, I am not building on their strengths and giving them the confidence to address what they might be concerned about, I am giving the message that they are not good enough and demoralising them.

In the potential model I am bringing their strengths to their awareness and enabling them to see what they are good at. Confidence builds and they address areas of their practice that they have concerns about or wish to improve upon.

This is not as easy as it sounds and this is one of the difficulties.

We mostly work in hierarchical situations. The skilled with the less skilled; those with more responsibility for decision making and those with less. This is the way of things but often within it, supervision is seen to be about keeping control while support is viewed as an open ended giving of energy that will provide people with the confidence to do their job. There appears to be a conflict of interests between these two things but there isn't unless that deficit model sneaks in. In a culture so obsessed with hierarchy, it's bound to in just the way that woman-centred care gives way to the need for control. This is why it is essential not just for every midwife to have supervision monthly as part of their contract, but for every supervisor to have undergone extensive retraining in person-centred facilitation and to have supervision on their own supervision and midwifery practice by a more experienced fully trained counselling supervisor.

This is not going to go down well. Everyone thinks they can do person-centred counselling, from social workers to ward sisters even when they haven't been trained. They are affronted by the suggestion that they are not qualified. It's just a thing tagged on to a 'real' profession isn't it? No, it's not, though there are huge parallels between how person-centred counselling works and what these caring professions state that their aims are. But

person-centred counselling is learned experientially, not from a few concepts added on. There is no other way. What you actually get if you don't put in the resources and the humility is a rerun where the deficit model of fear lurks beneath a veneer of niceness or counselling skills. When real risk enters the equation, trust goes out of the window and so does the ability to explore and reflect.

Of course, there are endless concerns, many of which I am looking forward to discussing. The question about this article, in accord with the feminine principle is not, "am I right or am I wrong" That would be coming from the masculine perspective. It is, "How can we use this beginning to thrash out our concerns regarding whether this new model of supervision is adequate?" Then perhaps we can begin to facilitate the process of having an excellent maternity service and keep it that way.

References and further reading

Belenky, M., Clinchy B., Goldberger., and Tarule, J: Women's Ways of Knowing, 1986

DOH Select Committee on Health 9th Report: Changing Childbirth

Edwards N: Protection NMC Midwifery Committee Annual Lecture 2.12.03

Freedman J and Combs G: Narrative Therapy 1996 Norton

Gilligan C: In A Different Voice 1982 Harvard University Press

Harding S. (ed): Feminism and Methodology 1989 Indiana University Press

Hinscliffe S: What Do Midwives Need To Know? Midwifery Matters Issue 98 Autumn 2003

Kvale: InterViews 1996 Sage

Mearns D. and Thorne B: Person Centred Therapy Today 2000 Sage

Pert C: Molecules of Emotion 1998 Simon and Schuster

Rogers C: Client Centred Therapy: It's Current Practice, Implications and Theory 2003 Constable and Robinson

Shohet and Hawkins: Supervision and the Helping Professions 1989 Sage

Worell J. and Remer P: Feminist Perspectives in Therapy 1992 Wiley

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