Never be afraid to question practice: the professional dilemma of a student midwife

Midwives must be autonomous practitioners, a stipulation of the Nursing and Midwifery Council (NMC, 2018). This article will present a case study in which I was presented with the challenge of conforming to a medicalised approach to care, or upholding my values and philosophies as a student midwife and using a non-interventionist approach to achieve autonomy. It was therefore essential for me to consider my skills and attributes as a student midwife, reflecting on and analysing key factors that determined my decision-making in practice. Throughout this article, I will refer to the woman I cared for as 'Faye'.

Abstract

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

Keywords

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

Case study

I first met Faye when she arrived at the obstetric unit for triage in suspected labour. I had already begun building a trusting relationship with Faye and she requested my care when admitted to the unit in established labour two days later. Faye had previously experienced a traumatic birth and described feelings of powerlessness and loss of control; she hoped that this labour would be positive and I was aware that she trusted me to help her.

Faye progressed well during her labour, which was considered low-risk. However, I was caring for Faye on a busy obstetric unit where the norm was to confirm full cervical dilatation with vaginal examination—a medical approach. I was also working under the supervision of a midwife who was perceived as preferring the challenges of high-risk labours, in contrast to my mentor who advocated normality and a 'with woman' approach. This presented me with a dilemma as I was practising outside of my comfort zone and my mentor's trust.

When updating my colleague on Faye's progression, I informed them of the physiological signs of full cervical dilatation and transition to second stage: urge to push; a change in Faye's behaviour (becoming quiet and 'zoned in'); distinctive visual appearance of rhombus of Michaelis; regular, longer, intense contractions; and rectal pressure. I also reminded my colleague that vaginal examination that had taken place 3 hours before had confirmed cervical dilatation at 8 cm.

I was then asked if I had confirmed full cervical dilatation with vaginal examination. I replied that I had based my information on the physiological signs of second stage and the previous vaginal examination, and that I had not performed another as Faye's labour was low-risk and she wished to achieve normality. My colleague requested that I perform a vaginal examination to confirm full dilatation for the ward co-ordinator.

I felt that I had already justified my reasons for not performing a vaginal examination; however, I felt pressurised to do so as my colleague was an experienced midwife and I was aware I was working under their NMC PIN. I was also aware that my colleague would have performed a vaginal examination. Following vaginal examination, full cervical dilatation was confirmed. Faye

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had a spontaneous rupture of membranes and a vaginal birth within 20 minutes of a vaginal examination.

I reflected on my decision with my colleague afterwards, and explained why I felt that I had let myself and Faye down. I was informed that even in low-risk labour it was good practice to confirm full dilatation regardless of physiological signs, as it allowed the ward co-ordinator to 'start the clock' to determine length of time for second stage and therefore prioritise care. To me, this confirmed a medical approach to care, rather than the 'with woman' approach that I was hoping to achieve.

By reflecting, I identified three influencing factors: the culture of obstetric units, the midwife-woman relationship, and the importance of assertive behaviours to achieve autonomy.

Reflection

Influential culture of obstetric units

In a study to identify the views of midwives working in various birth settings, Zhang et al (2015) concluded that all midwives shared the same philosophies of care: that practice should be woman-centred and autonomous. However, the setting in which the midwife worked often contributed to the degree to which these elements were incorporated in practice, as the midwives believed that it was harder to form relationships 'with-woman' and provide woman-centred care in an obstetric unit compared to an midwife-led unit.

Freeman et al (2006) examined how birth environments affected the care that midwives gave to women in low-risk labour, and found that midwives commonly discussed the frequency of vaginal examination in obstetric units. It was also established that midwives felt the common practice of intervention and the need for technology was influenced by the medical approach to the obstetric environment, supporting findings by Walsh (2012). Maintaining a holistic and individualised approach to care remained predominant in the midwives' practice, regardless of the medicalised culture of the unit (Freeman et al, 2006; Walsh, 2012).

Socialisation theory

Midwives have been shown to acquire the specific beliefs and knowledge of others to become accepted in the culture of the unit, therefore becoming socialised (Chamberlain, 1993). Medicalisation of childbirth has increased; therefore, it could be assumed that many midwives have been trained and socialised into a medical environment, where routine intervention is common practice (Parsons and Griffiths, 2007). In addition, Parsons and Griffiths (2007) found that more than two-thirds of midwives followed traditions and rituals regardless of evidence-based practice. Arundell et al (2018) found that medicalised units often led to a culture of obedience, whereby practitioners conformed to the culture of the environment and students felt that they must not 'rock the boat' (Henderson, 2008; Arundell et al, 2018).

Although Parsons and Griffiths (2007) focused specifically on oral intake during labour, the authors recognised that many midwifery practices were based on tradition rather than policy. It is thought that socialisation leads to diminishing autonomous practice and consequential lack of authority to challenge practice (Freeman et al, 2006). Traditional midwifery skills are at risk of becoming lost due to an reliance on technology (Walsh, 2012), with skills such as intuition and observation considered as nothing more than 'anecdotal evidence' without scientific evidence to justify their use in practice.

Expertise and intuition

This is reflected in the theory of novice to expert (Benner, 2001), which suggests that intuition and experience are integral to learning and development. This theory therefore concludes that expertise should be considered as a 'journey' rather than an 'arrival'. The ability to maintain a non-interventionist approach during women's labour is dependent on other skills gained through experience. Freeman et al (2006) found that midwives who practised autonomously without strict adherence to guidelines were those with more clinical experience and with the ability to challenge practice. As a student midwife and unable to work autonomously, I believe that I was yet to develop this expertise and confidence to challenge practice. However, if I had been working under the supervision of my regular mentor, she would have encouraged me to develop these skills further and I would have had self-belief in a non-interventionist approach to care. Therefore, as suggested by Jefford and Fahy (2015) skills such as 'let women labour' can only be achieved with expertise and competence. It could also be argued that medical approaches are used because newly qualified midwives are yet to gain the experience and expertise required to trust their intuition.

Vaginal examination vs non-intervention

In the obstetric unit where this case study took place, it was common to perform a vaginal examination to confirm full cervical dilatation, due to the heavy workload of each midwife. The ward co-ordinator had to be aware of how each woman was progressing in labour, to prioritise care and alert medical staff when each woman had reached full cervical dilatation. Vaginal examination is often used to prioritise care on busy wards (Deery and Hunter, 2010) but my belief in normality meant that I questioned this. Jefford and Fahy (2015) suggested that midwives should pay greater attention to intuition over technical brilliance, to ensure that they do not lose the ability to recognise deviations from the

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norm. The authors found that some midwives relied on technical assistance, such as CTG, over their intuition in low-risk labours to give them confidence in recognising deviations from the norm (Jefford and Fahy, 2015). Midwives should not prioritise becoming experts in using new technology, but instead trust their intuition and consolidate the skills acquired through experience of low-risk labour. This is despite the view of Parsons and Griffiths (2007), who suggest that socialisation into culture of practice can lead to midwives adopting medical practices because they are the norm in the unit.

My experience of working with a supportive mentor who championed normal birth gave me increased confidence in normality; however, working with another midwife who was perceived as preferring the challenges of high-risk labours, and who was unfamiliar with my practice, undermined this confidence. I was faced with a choice: to conform to the culture of practice, or to fulfil Faye's wishes by avoiding unnecessary intervention. It seems midwifery practice can often focus on 'getting the job done', rather than providing individualised, woman-centred care (Kirkham and Deery, 2006; Lipienné et al, 2014). This can lead to midwives feeling dissatisfied with their work, which can subsequently lead to ineffective practice, become defensive, burn-out, and midwives leaving the profession if such feelings are not resolved (Kirkham and Deery, 2006; Lipienné et al, 2014).

The midwife-woman relationship

A key role and underlining philosophy of midwifery practice is to be 'with woman' (Hunter, 2015). Building trusting relationships and helping women to have a positive experience of childbirth are the values I uphold in practice, and therefore I wished to maintain them when caring for Faye. Hauck et al (2007) concluded that a strong relationship between midwife and woman, in which the woman's involvement in the management of her care was promoted and her feelings of control strengthened, meant that women were more likely to consider their birth experience as positive, regardless of the physical outcome. McCourt and Stevens (2009) concluded that, when assessing their childbirth experiences, women valued information and control over their labour more than how complex or straightforward their pregnancy and childbirth experience was. I felt a strong need to advocate for Faye as I had begun building a relationship with her, and she trusted me to help her achieve a positive outcome. This trust has been said to be as important to the midwife as to the woman (McCourt and Stevens, 2009); therefore, I felt reluctant to intervene unnecessarily, as I did not want to jeopardise the relationship we had built.

Women must feel empowered by the midwife in order to strengthen their childbirth experience and there must be a partnership formed between the midwife and woman (Hermansson and Martensson, 2010; International Confederation of Midwives, 2011; NMC, 2014). Hermansson and Martensson (2010) found that empowerment was easier to understand through the absence of feelings such as powerlessness, dependence, and alienation. If Faye had these feelings while in my care, I would have felt I had done her an injustice in not working 'with woman'.

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Hunter (2015) suggests that building relationships happens over time, and although I had only cared for Faye during her labour and previous admission for triage, it was apparent we had a trusting relationship. Faye seemed comfortable discussing her previous birth experience with me, thereby reducing her anxieties (Hermansson and Martensson, 2010). An integral part of practice is to avoid situations that cause maternal stress and to promote normality; this was particularly important due to Faye's previous experience. Faye had knowledge of normal birth and attended parentcraft classes to support this. I also reinforced normality by discussing positioning in labour and pain relief options, to avoid assisted delivery. I therefore felt personally responsible to ensure Faye achieved the outcome she wished, as she trusted me to help her have a normal labour.

If midwives responded more to women's experiences, there would be an increased focus on social models of care (National Maternity Review, 2016). Holistic and personalised care models are ideal in providing a 'woman-centred' approach to services (National Maternity Review, 2016); however, the environment can be a major barrier. In a study of women's experiences and the importance of feeling informed and involved in decision-making, Hauck et al (2007) demonstrated that the strength of the midwife-woman relationship was reflected in the quality of care received. Exploring the variables that affect women's childbirth experiences allows midwives to consider what is important to women and understand how to build relationships to ensure a positive experience (Hauck et al, 2007).

The complexity of the relationship 'with woman' is explored in a secondary analysis of eight qualitative studies by Lundgren and Berg (2007). It may seem that women surrender themselves to the midwife during childbirth; however, Lundgren and Berg (2007) found

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that women still wished to maintain control but often lost trust in their ability to do so. This highlights the importance of the midwife-woman relationship in empowering the woman to trust in her ability to give birth. This analysis did have its limitations: all studies were qualitative and based in Swedish maternity units, therefore omitting quantitative research and that from other countries. However, the authors recommended that midwives should have a holistic approach to care, considering each woman as an individual and only intervening when necessary (Lundgren and Berg, 2007).

For this reason, as I believed that Faye was progressing well in her labour, I felt that a vaginal examination would be unnecessary: Faye was showing external signs of full cervical dilatation as she had a spontaneous rupture of membranes, a change in behaviour, rectal pressure and an urge to push. Faye's previous vaginal examination was 3 hours before these signs were observed, when cervical dilatation was confirmed to be 8 cm. I therefore believe that this is why the dilemma presented itself when it did.

Expressing assertive behaviours

By analysing Faye's case, it transpired that I was able to recognise the external signs of full cervical dilatation, yet was unable to voice my opinion and advocate normality. I was aware that the midwife with whom I was working would have performed a vaginal examination to confirm full dilatation and therefore I felt pressurised due to this. I realised that I did not lack skills or confidence in supporting a non-interventionist approach, but instead I lacked the assertive skills required to express my opinions, especially as it contradicted my colleague. Assertive behaviour includes the ability to make independent decisions, which is vital to practice, and good communication, not only between midwife and woman but also between colleagues (NMC, 2018). Assertive behaviour is strongly encouraged in midwifery (Timmins and McCabe, 2005); however, there is limited research into the assertive skills of students. This is an area that could benefit from further exploration to improve students' confidence and development in practice (Ibrahim, 2011). It is believed that a lack of assertiveness may lead to low self-esteem, which is unhealthy for the midwife and consequently affects care (Timmins and McCabe, 2005).

Factors such as a low confidence, a lack of knowledge, low self-esteem, fear of hostility and concerns over how one is viewed by a colleague all contribute to preventing assertive behaviour (Ibrahim, 2011). Timmins and McCabe (2005) found that nurses and midwives often expressed assertive behaviour as a result of their responsibility for the patient. Timmins and McCabe (2005) also found that participants feared the negative response from colleagues when being assertive; this was apparent in the case study above, as I avoided challenging common practice (and practice perceived to be favoured by the midwife with whom I was working), for fear of a negative response. As a result, I performed a vaginal examination, which not only meant that I was conforming to the culture of the unit, but I also contradicted the values and philosophies that I regard as central to my practice. I regarded performing a vaginal examination to be a failure of my care, because I conformed to practice rather than advocate for Faye, despite my wish to empower her by maintaining a non-interventionist approach.

Assertiveness in newly qualified midwives

Hobbs (2012) explored the experiences of newly qualified midwives during their first year after qualification and in their transition to qualification. This enabled me to compare and to analyse how I could further develop my own practice. Participants described feeling a need to 'fit in', which prevented the development of their autonomy (Kirkham, 2010), and how the midwifery culture that they observed was not 'with woman' and did not promote normality, which were beliefs that were essential to participants' practice (Hobbs, 2012). Newly qualified midwives' practice was also deemed as submissive and compliant, as the authority of more experienced staff was rarely challenged (Hunter, 2005).

However, practitioners have been shown to dissociate themselves from conformity in practice as they grow in confidence (Hunter, 2005), and the participants in the study by Hobbs (2012) suggested that they felt more able and prepared to challenge practice towards the end of their first year of qualification, therefore enabling autonomy.

Hunter (2004) identified the ideologies of 'with institution' and 'with woman' to be significant in relationships with colleagues, which then affected self-esteem. Those who idealised the 'with institution' concept tended to be more experienced midwives, compared with newly qualified midwives: as student midwives and during the first year of qualification, midwives often conformed to institutional expectations (Hunter, 2009); however towards the end of their first year, newly qualified midwives were more likely to support a with-woman approach (Hobbs 2012). This supports Parsons and Griffiths (2007) theory of socialisation; however, it could be argued that the evidence gathered by Hunter (2004) was one-sided, as experienced midwives did not participate, meaning that it considered only the perceptions of student midwives. It is imperative that influential factors in driving practice towards conformity rather than autonomy are recognised, as newly qualified midwives often conform to institutional expectations (Hunter, 2009).

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Improvements to practice

This case study highlighted that I was overly self-critical and that I always strived for perfection. Feedback from mentors had always been positive, although it had also suggested that I should have had more self-belief. I had placed a great amount of emotional pressure on myself in striving for Faye's desired outcome due to the relationship we had built, and I realised the need for a balance between normality and empowerment. I believed that I was unable to advocate for the care I felt Faye deserved due to a lack of assertiveness; however, although I intervened, this did not necessarily affect Faye's experience, as I discussed the examination with her so that she was fully informed (Anderson, 2010). Exploring this case study has highlighted the criticism I placed on myself, although the outcome of the situation was positive. Striving for unrealistically high standards of care can be damaging for both patient and midwife, often leading to a lack of job satisfaction and burn-out (McCourt and Stevens, 2009; Kirkham, 2010).

This case study led me to consider how to develop assertive behaviour and autonomy. Support from colleagues and collaborative relationships has been shown to help the transition to qualification and increased confidence in graduates, enabling them to promote women-centred care and normality and to challenge practice (Fenwick et al, 2012). Sully and Dallas (2010) suggested that for assertive communication to be successful, the practitioner must first develop confidence in the relevant working environment—in this case, the obstetric unit. Assertion is an open and honest form of communication that also considers others' views (Potts and Potts, 2010) and an essential element of proficiency (Sully and Dallas, 2010). By being appropriately assertive in practice, the common philosophy of women-centred care is maintained and conflict should not arise; however, ward culture or working with experienced colleagues can make this challenging (Sully and Dallas, 2010). Developing this skill while I had the support of my mentor therefore eased my transition to qualification (Fenwick et al, 2012). I requested to lead parentcraft sessions and the handover of care to experienced and senior staff, which developed the communication skills I needed to assert myself (Potts and Potts, 2010; Sully and Dallas, 2010) and allowed me to overcome common barriers, such as the influence of managers and ward culture (Timmins and McCabe, 2005).

I believe that reflection and continual professional development are key to the midwife's role. I kept a reflective diary to document events in practice, which I discussed with my mentor. I also noted positive aspects of my practice, which increased my confidence, discouraged me from being overly self-critical and prepared me for autonomous and accountable practice (Hobbs, 2012).

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Key points

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

Conclusion

This article has explored the case of Faye, whom I met as a student midwife. I had to decide whether to use vaginal examination to confirm full dilatation or observe Faye in labour, supporting a non-interventionist approach to care. There were three influential factors that became apparent: the culture of obstetric units, the midwife-woman relationship, and the importance of assertive behaviours to achieve autonomy.

I ignored my own values when I used intervention to confirm full cervical dilatation, therefore conforming to the medical culture of practice in the unit. I highlighted areas for practice development to enable me to challenge practice and to avoid conforming in the future, and a major finding was a lack of assertiveness. Although I had the knowledge and skills to identify labour progression and promote normality, I did not assert my views effectively. The literature showed that communication and relationships with colleagues are important to autonomy and assertiveness. I therefore addressed these elements by organising to lead parentcraft classes and work in an midwife-led unit. This improved my confidence in the work environment, enabled me to act assertively and allowed me to practice with minimal intervention, with those who held values similar to my own.

In addition, I also had unrealistic expectations of myself, which could have negatively affected my professional development. Seeking support from my mentor and using reflection allowed me to be less self-critical and equipped me with skills to improve my practice, so that I can give woman-centred care and uphold my values through transition and qualification. BJM

***Declaration of interests**: The authors have no conflicts of interest to declare.*

***Review**: This article was subject to double-blind peer review and accepted for publication on 5 June 2019.*

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CPD reflective questions

- As a midwife, how would you tackle a similar dilemma in practice if you were working in a medicalised culture?
- Assertive behaviours can achieve greater autonomy. How can we prepare students to become more assertive in preparation for the transition to practising as a newly qualified midwife?
- Assertive behaviour is considered a communication process that is vital to practice. Has there been a time within your clinical practice you were unable to openly express your feelings, and how did you overcome this? What support did you seek?
- A key role and underlining philosophy of midwifery practice is to be 'with woman'. How do we ensure midwives remain autonomous and what improvements to practice could be suggested?

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