

Section 3: Grounding the study

Each step I take is on a ground that is there already, that has been there for some time...

The purpose of this section of the journey is to explore the literature that relates to the study, the ground already covered by others before me and previous knowledge on which I can draw.

3:1 Being a midwife

Being a midwife is meaningful to me, as indicated in the previous personal story. However, personal meanings of being a midwife globally have had little attention in research terms. Studies have tended to ask women about midwives through their experience of being cared for, their satisfaction, and the outcomes (El-Nemer et al 2006, MacKinnon et al 2003, Lavender et al 1999, Berg et al 1996, Halldorsdottir & Karlsdottir 1996, Powell Kennedy 1995). Midwives have also been asked about their practice (Powell Kennedy et al 2006, 2008, Hyde & Roche-Reid 2004, Powell Kennedy et al 2004, Hildingsson & Haggstrom 1998, Todd et al 1998). Kathleen Fahy (1998:14) argues:

midwives' way of being is constrained by the need to be doing things: *doing* routine observations, *doing* vaginal examinations, *doing* procedures, *doing* deliveries. Midwives who want to fulfil their essential role of 'being with' women are challenged to defend themselves against charges of 'doing nothing'.

In the previous section relating my story I state that the meaningful aspects of being a midwife lie in the concepts of being 'with woman', and of building up trusting relationships. Midwives in an American study described the importance of these special relationships with women (Doherty 2010). These feelings were also expressed by midwives who were able to practise as 'case-load' midwives, where they talked about being 'real midwives' (Beake et al 2001). This study indicated that the way practice was organised enabled a more meaningful experience for the practitioners. This was also illustrated in further studies relating to case-load midwifery, where midwives were satisfied by the reciprocity of the relationships (McCourt and Stevens 2009). A further study, with midwives from different areas of practice, that aimed to find out concepts of midwifery, also illustrated that midwives found the rapport built with women to be meaningful as well as continuity of the

relationship (Thomas 2006). These midwives wanted to 'make a difference' for the women in their care, demonstrating values of altruism, but also gaining personally through the relationship. Similar aspects also emerged in a Swedish study where midwives gained satisfaction in their role through development of a long-term relationship (Hildingsson and Haggstrom 1998), and in a study of Japanese midwives who wanted to bring happiness and joy to the women in their care, as well as positive change and lifelong health (Gepshtein et al 2007).

For community based midwives in the UK the relationships with women could be emotionally rewarding or challenging (Hunter 2006), with perceived lack of understanding and support from managers and supervisors (Deery 2005). In addition midwives are required to negotiate conflict in relationships with other midwives (Hunter 2005), as well as cope with their personal experiences as women (Bewley 2010).

I recognise the view that meaning may be imposed on us through cultural and social construction (Kincheloe 2005) in the way we are living-working-being. The meaning of midwifery is thus socially, culturally and historically constructed for the participants of this study.

3:2 *The art of midwifery*

I am focussing in this study on the 'art' of midwifery for a number of reasons. From my current perspective as an observer of midwifery in practice I hold the view that there has been a loss of a whole-person approach to care. I believe this is one of the key aspects of a midwife's art a way of being 'with woman', which is the literal old English meaning of midwife (Kaufmann 1993). This change has been accompanied by increase in technological intervention (Mead 2008, Davis-Floyd and Mather 2002, Cowie and Floyd 1998, Wagner 1994) and loss of professional control (Henley-Einion 2009, Lewis and McCaffrey 2005, Sandall 1995, Wagner 1994).

In my current role as an educator I facilitate sessions that are about the 'art' of midwifery. The assumption of this is that midwifery is an 'art' and that it is possible to teach it. The use of the word 'art' has been used in relation to professional nursing practice, with the suggestion that it is both an art and a science since the days of Florence Nightingale, when she described it as the 'finest of the fine arts' (Cumbie 2001). Midwifery has also been consistently described in these terms (Davies 2007,

Marland 1994, Silverton 1993). It is one of the most ancient woman-based professions with its roots in the local community, where the skills required have been passed down through generations. Midwifery has also been termed a 'craft'. The concept of 'craft' may be regarded as being of less worth (Clover 2005) though Wickham (2007:64) expresses concern at debating the differences between the words, suggesting instead that:

it matters less what we call it than what we actually do.

By this she places her discussion in the realms of the practical nature of the role. Clarke (2002: 85) however describes the art of midwifery in terms of:

the ethereal and very personal dimension to a [personal philosophy of midwifery] expressed in the instinctive, personal behaviour of the midwife, which is often difficult to vocalise (Bryar 1995). The art of midwifery includes personal knowledge, femininity, and scientific knowledge gained from literature.

Michel Odent (2005) refers to the 'art' being in the 'personality, the way of being, the background, the experience and the intuition' of the carer. Aspects of the 'art' of midwifery are also listed as 'intuition, personal knowing, embodied knowing and contextual knowing' (Hunter 2008). The personal meanings that midwives have about the role appear to have significance. However, as mentioned above the research evidence establishing what these meanings are is currently limited. This makes the teaching of the 'art' to students a challenge and is significant to this study.

Whereas this study focuses on the individual practitioner it is also stated that midwifery management structures should be addressed (Oudshoorn 2005), and that a 'midwifery model of care' is the most appropriate for the art of midwifery to be achieved, requiring:

- one-to-one relationships through the pregnancy continuum
- appropriate objectives and support from the midwife
- communication promoting partnership and personal control for the woman
- respect for individual culture and needs, seeing birth as a 'social, psychological and spiritual event'
- use of counselling skills

- skills of inactivity, positive reinforcement and creativity during labour

Such models have been consistently presented as the ideal ways for midwives to practise (Pairman 2010, Page et al 2001, McCourt et al 1998, Flint and Poulangeris 1986), yet achieving this appears to be a challenge in the current context of midwifery management. Though recent texts have begun the discussion around the use of art as tools in midwifery (Demecs et al 2010, Davies 2007, Anderson and Davies 2004, England and Horowitz 1998) or have presented art of pregnancy and birth (Emery and Emery 2007) there is limited research within an academic context. It is clear that there are different meanings and contexts for the use the word 'art': for example, the 'art' of caring, art as an expression and art as creativity.

Concepts in relation to the art of nursing have been explored and hold some relevance to professional aspects of midwifery. The art of practice has been described as the 'art/act of the experience-in-the moment' (Chinn 1994:24). Appleton (1994:91) researched the experience of the art of nursing and extricated the following themes:

- Being there
- Being with each other in understanding
- Creating opportunities for fullness of being
- A transcendent togetherness
- A context of caring

These themes have also been thought of as demonstrating spiritual care (Hall 2001), which implies that the spiritual nature of caring may be linked to what is described as the art of caring. Verena Tschudin (1999) states that 'nurses matter' as the type of care given will affect the patient long term. Midwives are also regarded to 'make a difference' and matter (Davis-Floyd 2005) and evidence shows that midwifery-led models:

- benefit women and babies
- are best in small, relationship-based situations
- are cost-effective (Devane et al 2010).

Midwives can thus 'make a difference' by how they organise care.

Further, Biley (2005) writes of the 'invisible' knowledge of nursing, and that nurses make a difference:

by simply being with their patients and their relatives during difficult times (p41).

This 'invisible' or tacit knowledge (Polanyi 1969) is connected to the art of practice (Appleton 1994) and could be an indication of the spiritual. Intuitive knowledge is regarded as significant for midwives (Fry 2007), with it being regarded as an essential component of the 'post-modern' midwife, who can move regularly between the two models of biomedical obstetric care and holistic frameworks (Davis-Floyd and Davis 1997:320). They further suggest that intuition is connected to the 'physical, emotional and spiritual connection' with themselves and with women (p339).

The issues mentioned here will be explored further later alongside comments made by the participants of this study.

3:3 Holistic care and midwifery

In the previous section I explored my ontological perspective and beliefs including holistic care and spirituality. Artistry in midwifery is underpinned by the aim within UK midwifery to have a holistic approach. This philosophy is inherent in the standards for midwifery education (NMC 2009) with the implication that programmes should have a focus aiming to enable students to give 'whole person' care. Included should be development of knowledge of spirituality as part of a 'holistic' paradigm and the impact of this on the woman and her family and the unborn child. It is unknown how all current midwifery programmes in the UK address this requirement, though informal questioning of some midwife educators indicates this may not be widespread. Without midwives having personal self-knowledge and awareness of their own values and beliefs such an approach to education is challenging. Developing education sessions that will enable midwives to consider these beliefs may thus be of benefit.

The recent change in the educational standards demonstrates an assumption that education providers are clear as to what 'holistic' care means in order to teach it. The concept of a 'holistic' philosophy to care in western medicine appears to have originated though the work of Cicely Saunders in the modern hospice movement in the 1960s (Greenstreet 2006:25). However, recognition of the importance of whole

person care is not unusual in other cultural forms of health care (Clark Callister 2001, Clark Callister et al 1996).

In addition to 'holistic' student midwives in the UK are expected to provide 'women-centred' care (NMC 2009). Nicky Leap (2009) argues that the term should be 'woman-centred' with care that is focussed on the individual woman's needs, rather than 'universalization'.

Placing the person at the centre of care and including a multidimensional approach is thus understood to be the key to 'holistic' or whole person care. My lines of enquiry in this study lead me to ask whether there is an inherent link between the holistic 'art' of midwifery and this so called 'spiritual' nature of the role.

3: 4 Education for holistic care and artistry

The requirement for a holistic approach to care indicates a need for students to develop appropriate knowledge of all aspects. There appears to be agreement that educating healthcare students around spirituality is of benefit but how to facilitate that learning is less defined (McSherry et al 2008, Mooney and Timmins 2007, Narayanasamy 2006, Stern and James 2006, Pesut 2002, McSherry 2000). The suggestion that creativity may be an expression of the whole person (Stone 2003, Burkhardt & Nagai-Jacobson 2002, Howard 1998, Allen 1995, Kandinsky 1977) implies that the use of creative methods in education may be appropriate to facilitate learning about these issues.

The psychotherapist Winnicott argued that creativity is 'play' and that this uses the 'whole personality and enables discovery of self' (Winnicott 1971:53), which all works of art produced may not allow. From this it could be argued that the fact something has been devised or made by someone would mean it is of value to that person concerned, that it is part of their inner expression, no matter what others perceptions of the piece may be. Mark Johnson (2007: 208) states that:

art matters because it provides heightened, intensified, and highly integrated experiences of meaning.

He continues:

We need a philosophy that sees aesthetics as not just about art, beauty and taste, but rather as about how human beings experience and make meaning. Aesthetics concerns all of the things that go into meaning-

form, expression, communication, qualities, emotion, feeling, value, purpose and more (p212).

Edassery and Kuttierath (1998) also write of the importance of the 'rediscovery of self-worth' and that use of creative arts may help this process. This implies that facilitation of students creatively may enable greater personal understanding of the 'self' with later ability to transfer this into a more holistic approach to care.

3:5 Creativity and midwifery education

It is suggested that current educational systems are stifling 'creative potential' in health care students (Fasnacht 2003) and that most students remain passive (Davies and Wickham 2007:191). Others write that 'artistic modes of thought and aesthetic experiences are essential to the cognitive and expressive developments of students' (Slattery and Langerock 2002). Although the use of creative methods of teaching are recommended in some higher education texts (Heron 2002, Sternberg and Williams 1996) they are not extensively used in midwifery education (Davies and Wickham 2007) and are currently rarely evaluated. In an Australian context the use of creative arts on a midwifery course demonstrated the benefits the students perceive from this method of learning (Jackson and Sullivan 1999). However, no attempt at evaluation of what was produced or the meanings the students derived from the experiences appears to have been made.

A more recent paper describes an educational project with student midwives using clay to illustrate their midwifery philosophy (Walker 2007). Evaluation of the process showed the participants valued the experience. Clarity is required as to whether there are any problems or limitations related to this method of learning for the students or teachers involved. It has been suggested that encouraging the development of an imaginative approach to care may promote openness to how they may then respond to those they care for in the future as they will then recognise these aspects in others (Palmer 1995). A supposition is that increasing knowledge of a more holistic approach in this way may encourage a practice that becomes more holistic and women-centred.

3:6 Knowledges of the research

As I move on the journey it takes twists and turns and in doing so I pick up knowledge on the way...

If I believe that humans are 'holistic' beings then this has implications for research and how I approach the participants. I believe that research is of value, but the paradigm used should 'fit' the questions asked (Silverman 2010:9-10). In establishing that an individual participant will be influenced by the historical, societal, cultural and personal elements I identified this influencing myself then I consider that a 'holistic' approach to the research of participant's voices should also be taken. The individuals views/meanings voice is of worth and value. I believe they are integral to the study and need to be 'heard'. In essence this leads to questions about interpretation and presentation. I would like to 'do justice' to the 'whole' person and not to fragment them, but if I believe in presenting the participants as 'whole' then reducing their words, followed by interpreting with my voice will be challenging. Presenting them as 'whole' mini case studies could have ethical implications, as they will then be more recognisable to those they work with, in addition to approaching the vast amount of material that is collected.

A challenge also lies in the multitude of 'layers' in the type of data that is gathered, as well as in the 'voices'. The underpinning ontological perspectives lead to the need to address differing epistemological dimensions. This is highlighted by Jennifer Mason (2006:10) who writes that 'social experience and lived realities are multi-dimensional' and that researchers should use more than one dimension to explore the potential:

emotional, sentient, imaginary, spiritual, habitual, routinized, accidental, sensory, temporal, spatial, locational, physical/bodily/corporeal, biogenetic, kinaesthetic, virtual and probably more

aspects of relationships (p11). Fragmenting the voiced 'lived realities' of the participants for the purpose of a study feels limiting and therefore a more multi-dimensional approach may be more appropriate in an holistic study. Further Tina Miller (1998:58), relating to research on childbirth, writes of it as being 'professionally defined, but personally experienced transition'. I question then the impact on midwives, especially those who have also given birth themselves. She continues by describing the different layers of voices: (p59)

- 'public'- ' the professional definitions of childbirth maintained and practised by medical and health professionals'
- 'private'- ' the lay knowledges...made up of informal interactions' with family and friends

- 'personal'- 'sense of self in an individuals account which does not fit' with above

As I listen to the midwives in my study they too give different 'voices'; those that they have professionally constructed: those they have developed in the context in which they are working, which could be described as the 'cultural norm': and the personal meanings that they then ascribe to the role. There is potential that I could choose to use this framework to interpret the material, to address some elements of these layers.

The feminine nature of the role has implications for the way the study is conducted, recognising that women are those that are being cared for and that the majority of midwives are women. For example in 2008 one hundred and four men registered as midwives, alongside over twenty four thousand women (The information centre 2010). In my research diary I write:

May 10th 2007

The issues of masculine and feminine are interesting and something I am resonating more with, relating to the value and worth of what I am trying to achieve. I think I have some kind of conditional response that this is of less worth because of our move toward the gendered expectations of science and technological stuff in midwifery.

I am reflecting on the current trend in health service research toward evidence-based care and reliance on experimental research to provide that evidence. This is illustrated by 'Graham', a Masters degree student based in the NHS who writes:

So what we've got is a view that all research should be 'evidence-based'-using control groups, double-blind testing and the like. What I wanted to do was nothing to do with patients...and I wanted to use an action-research framework to do this. Clearly, I work in a system that's used to working in a strong scientific clinical tradition, and qualitative research just simply wasn't well understood or supported. They told me my proposal was too 'touchy-feely' and not valid as research. (Broussine 2008:16)

Midwifery as a profession has had practice grounded more in the 'touchy-feely' than in the scientific for generations which implies that qualitative research methods

should be more 'acceptable'. However, this is currently more complex as midwives are competing against the power of medicine, a male dominated profession, and have lost a significant amount of power in education by moving into large Higher Education Institutions (HEI), as discussed in section two.

In western history the role of the midwife as 'wise woman' who knew healing lore was viewed as influential and powerful (Ehrenreich & English 1972, Kitzinger 1988, McCool & McCool 1989, Achterberg 1990). Influence of male-dominated religious groups and medical men in mediaeval times, when women were not allowed to receive education, saw this female dominated 'healing' as 'a pagan' influence, challenging male authority (Kitzinger 1988 :4). Suppression of these ancient midwives began and such power struggles still remain (Lawrence Beech & Thomas 1999).

The different layers described previously are an illustration of the complexity of professional practice in midwifery. The complexity of artistry in professional health care practice has been described (Titchen and Higgs 2001:281). They propose artistry is generated through improvisation between intuition, imagination, and the unconscious. They suggest various issues intertwine and interplay:

- The perceived or stated needs of the client
- The clients' interpreted needs
- The practitioner's technical competency
- The practitioner's ethical competency

In addition they add as a central aspect the issue of spirituality, the Muse, the Greater Self or soulfulness (p289). They suggest here that this is the place of transformation and transcendence. Leight (2002:109) talks of this as being 'aesthetic knowing', which involves 'integration of the total knowledge spectrum in practice' that leads to transformation. Peggy Chinn, in writing about the 'art' of nursing states:

Like other descriptions of women's ways of knowing and being in the world, aesthetic knowing that gives life to the art of nursing does not grow out of reasoned, systematic, linear, problem-solving modes of thinking or action. Rather, aesthetic knowing involves an embodied grasp of situations and intimate experiences with the deepest and most significant life events that have been traditionally and cross-culturally associated with women's experience- birth, death, sorrow, joy, pain, life transitions (1994:37).

Such knowledges are deeply embedded in the practitioner and potentially internalised, due to personal and professional history. I believe that the use of artistic methods of education and research may be a way of bringing out 'internalised' knowledge as 'self' expression perhaps of things that couldn't be 'voiced' in another way (McMurray et al 2000). They tap into other parts of the brain that have not been used recently so give an holistic approach to research. Dewey (1934: 84) stated that: 'Science states meanings; art expresses them'. Chinn and Watson (1994: xv) also write that:

Art captures, expresses and recreates humanity and life in all their various and diverse forms. Art evokes spirituality, inspiration, imagination, creativity and dedication. Art is the life's spirit.

My belief in the value of artistic methods comes from experimenting with their use with student midwives in education. Evaluating the process demonstrated the benefits they have gained through it (Mitchell and Hall 2007, Hall and Mitchell 2008). From a midwifery perspective it could be challenged that the philosophy of giving women-centred, holistic care, requires different methods of facilitating deep learning within individual students (Davies 2004) and different ways of knowing than the scientific knowledge more 'expected' in midwifery today (Wickham 2004a).

3:7 Considering validity

Verification by participants is considered an appropriate way of ensuring validity in qualitative studies. 'Member-checks' are used as a way of clarifying the data collection process, and often used at the end of the process of synthesis. However, Margarete Sandelwoski (1993) is critical of this process, with the potential of individuals unable to recognise themselves in the process, as well as not understanding the language used. Triangulation is also used where different methods are used to establish different meanings. In this study I am using different methods to aim for an holistic approach. I am, however, struck by Laurel Richardson (2003) where she views triangulation is a 'rigid, fixed, two-dimensional object' but that instead qualitative researchers recognise there are more than three sides and that the concept of 'crystallization' should be used. This:

combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multidimensionalities, and angles of approach. Crystals grow, change, alter, but are not amorphous. Crystals are prisms that reflect externalities and refract within themselves,

creating different colors, patterns, and arrays, casting off in different directions. What we see depends on our angle of repose. (p517)

She goes onto say:

Crystallization, without losing structure, deconstructs the traditional idea of 'validity' (we feel how there is no single truth, we see how texts validate themselves), and crystallization provides us with a deepened, complex thoroughly partial understanding of the topic. Paradoxically, we know more and doubt what we know. Ingeniously, we know there is always more to know (p518).

In creating a study where I am focussing on the 'whole' individual as much as possible, this concept of crystallization appears relevant as I recognise how different views of the variety of the information produced could bring different meanings and interpretations. I recognise that research is a construction, taking parts out of the whole. In considering a holistic approach to research I am not comfortable with this form of reductionism. I also recognise that some reduction of the material will be required in the constraints of this thesis. I intend therefore to present different ways of looking at the material to demonstrate different facets of the 'crystal' through which to view the material gathered.

In considering the steps required to claim validity in this study I intend the following:

- Verification by self: During the process I am being open about my beliefs. I am taking steps to be reflexive and to aim to consider all options in the heuristic process, including the impact of my subjective views and history on the research process (Maso 2003: 40). Michael Quinn Patton (2002: 548) writes that for artistic work:

The analyst's interpretive and expressive voice, experience, and perspective may become central to the work as depictions of others

- Verification by participants: Despite the criticism by Margarete Sandelwoski (2003) above I intend to return material about the individual participants to them for a reflexive response to ask 'Is the material trustworthy in that they recognise themselves?'
- Verification by others: I plan for this study to share the information with others to ask if they feel the text is credible. Shaun McNiff (1998: 38) writes:

the validity of art-based knowing and inquiry is ultimately determined by the community of believers who experience first hand what the arts can do to further human understanding.

This implies that the 'community' shared with will need to have some knowledge of the arts as a form of research. Through sharing with my midwifery colleagues they may resonate with the midwifery based material but there would remain some question about the arts based material. I question whether their individual understanding of my reality will be the same or different and ask if this matters and how? I also intend to share some of the material at arts-based conferences throughout the process.