Section 8: Multi-dimensional meanings of the essence of being a midwife.

Walking on the journey I have encountered a number of midwives who have shared with me their lives in a multidimensional way; mostly through their words and stories, but also through being willing to ‘play’ through artistic representation of their thoughts and feelings at this time. Here are the gifts they entrusted to me…

As with any qualitative study a considerable amount of material has been gathered from the participants. In previous sections I have written that my philosophy for carrying out the study stems from my beliefs about the nature of human beings. As a result of my philosophy I aim to consider the participants as a whole, recognising the kaleidoscope of multidimensional meanings that they give to midwifery, through the use of different mediums or words and artistic representation. However, exploration of the material also demonstrates that there are multidimensional meanings depending on which way you look at things as a researcher.

8.1 Who are the participants?

I consider carefully how I will present the demographic information about these participants. I would like to stay true to the holistic approach to this study and present them as individuals throughout, though have indicated ethical dilemma about this. Each person has chosen their own name for the study. I decide therefore to present them in this way, (see 8: Table 1), disguising some of the specific data in order to protect their identity. The headings relate to questions on the questionnaire.

The group of midwives are all experienced in their practice. None had been qualified for less than fifteen years, and most were closer to twenty five years. This length of experience gives strength to their views in this study, as indicated previously, they had been practising through significant times of change in work practice. All the midwives are mothers. Their personal experience of birth may have an impact on their views of the meaning of the art of midwifery. However it also indicates that these midwives have particular determination in choosing to stay as midwives whilst juggling considerable care roles over time.
### Table 1: Details about the midwife participants from questionnaire

<table>
<thead>
<tr>
<th>Name</th>
<th>Age group</th>
<th>Birth experience</th>
<th>Artistic training</th>
<th>Current creative activity</th>
<th>Religious involvement</th>
<th>Spiritual involvement</th>
<th>Current work area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archie</td>
<td>40-45</td>
<td>Two own-complicated</td>
<td>None</td>
<td>Cooking, baking</td>
<td>None</td>
<td>Regards herself as spiritual - people confide in her, walks to reflect and likes being next to nature</td>
<td>Hospital delivery suite</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two friends-straightforward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connie</td>
<td>36-40</td>
<td>Three- some complications</td>
<td>Up to GCSE</td>
<td>Sewing, cross stitch</td>
<td>None</td>
<td>Pilates</td>
<td>Hospital delivery suite</td>
</tr>
<tr>
<td>Jennifer Anniston</td>
<td>40-45</td>
<td>Two-some complications</td>
<td>GCSE art</td>
<td>Swimming</td>
<td>None</td>
<td>Talking to children; meeting regularly with girlfriends who uplift her</td>
<td>Hospital delivery suite</td>
</tr>
<tr>
<td>Kerry</td>
<td>30-35</td>
<td>One- some complications</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td></td>
<td>Community</td>
</tr>
<tr>
<td>Lizzie</td>
<td>46-50</td>
<td>Five-straightforward</td>
<td>None</td>
<td>Textiles, dressmaking, fabric</td>
<td>Regular church</td>
<td></td>
<td>Hospital delivery suite</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>crafts, card making, badge</td>
<td>attendance and charity work</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>making, face painting, cross</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lucy</td>
<td>40-45</td>
<td>Three-other family</td>
<td>None</td>
<td>Cooking, card making, decorating,</td>
<td>None</td>
<td>Keep fit, exercise, cycling</td>
<td>Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two own-complicated, one</td>
<td></td>
<td>sailing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>straightforward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Dix</td>
<td>46-50</td>
<td>Two-one complicated, one</td>
<td>Up to GCSE</td>
<td>Children’s birthday cakes</td>
<td>None</td>
<td></td>
<td>Hospital delivery suite</td>
</tr>
<tr>
<td></td>
<td></td>
<td>complicated, one</td>
<td>and painting any</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>straightforward</td>
<td>evening class</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pamela</td>
<td>40-45</td>
<td>Five friends attended</td>
<td>None</td>
<td>Scribbling with child</td>
<td>Regular church</td>
<td>Singing in the car: makes her feel renewed. Influenced by nature, that renews her belief in God</td>
<td>Hospital delivery suite</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two own-complicated</td>
<td></td>
<td></td>
<td>attendance and charity work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sally Ann</td>
<td>46-50</td>
<td>Four-one complicated, three</td>
<td>GCSE music, Flute</td>
<td>Knitting, cross stitch</td>
<td>Strong personal</td>
<td></td>
<td>Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>straightforward</td>
<td>grade 6</td>
<td></td>
<td>belief, occasionally</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>attends church</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Three of the midwives are primarily based in the community during the study. However all the participants had worked in either the hospital or community areas at some time in their career and enabling a wide view about what is happening currently in midwifery practice.

Some of the midwives have concepts of religious or spiritual awareness. It was felt appropriate to ask this question due to the holistic focus of the study and the awareness that participants who have this focus may answer questions around holistic care in a certain way. Though I have no intention to map the comments they make in the study to their personal views I am presenting the data as this was asked on the questionnaire. In addition information about the participants’ creative activities and artistic training are presented, though will not be commented on or mapped against their answers.

8.2 The research questions

The key research questions for this study are:

- What are the meanings ascribed to being a midwife and the art of midwifery practice by a small group of qualified midwives using creative inquiry?

- What is the impact of creative inquiry on the meaning they ascribe to being a midwife and the art of midwifery?

- What meanings emerged through adopting a creative, bricolage methodology?

- What is the impact on the researcher of this study?

In the previous section I described how I created ‘text quilts’ from the vignettes devised from all the information provided by the midwives. In addition the midwives had produced two created pieces each. The intention in this section is to demonstrate some of the different ways the materials can be explored using differing techniques, in line with a bricolage form of inquiry. The issues presented will be a preliminary attempt at viewing all the material in a holistic way. With the amount of material that has been generated it is not
possible to utilise all the data, therefore I have been selective and indicate why I have chosen certain material to present here.

8:3 Mapping the text quilts

As indicated previously I changed the linear state of the vignette into a visual representation of the individual, matching the concept of bricolage as a quilt principle (see figure 7:3). Presenting the individuals words in a visual and colourful way shows the participants in a different dimension. I have had to make a pragmatic choice about completing a ‘text quilt’ for each participant due to time and word constraints, and stop at making four. However I intend to continue this process for all the participants at a later date. I wish to consider interpretation in the light of Joe Kincheloe’s (2005:346) assertion that:

…bricoleurs seek to cultivate a higher form of researcher creativity that leads them, like poets, to produce higher concepts and insights about the social world that previously did not exist. This rigor in the absence can be expressed in numerous ways including the bricoleur’s ability:

- to imagine things that never were;
- to see the world as it could be;
- to develop alternative oppressive existing conditions;
- to discern what is lacking in a way that promotes the will to act; and
- to understand that there is far more to the world than what we can see.

This last statement reflects the nature of sacred inquiry (Reason 1993:273) and intuitive inquiry that Rosemary Anderson (1998:3) describe as recognising the ‘non-rational’. It is argued that in life:

Intimate, personal, sometimes nonsensical experiences are the ones that seem most important because they bring most meaning to life… Similarly a midwife’s ordinary practice of being with the woman can be experienced by the midwife in quite extraordinary — nonrational —ways (Parratt & Fahy 2008:37).

They conclude that:

Believing that the nonrational is important and should be considered in decision-making is not the opposite of rational, i.e. ‘irrational’. Considering the nonrational is an expansion of thinking that takes both the rational and the nonrational into account. We therefore believe that inclusion of the nonrational is, indeed, sensible midwifery ( p 41)

The representation of the participants as ‘whole’ through the use of the ‘text quilt’ aims to honour the participants as whole people. The interpretations
presented here will be a preliminary examination of some of the information that can be elicited from this method of interpretation.

The text below illustrates an alternative way of interpreting the material through the use of the text quilt. Though it is in a sense ‘playing’ with the data, in line with recognition of the multidimensionality of a person it provides a multidimensional way of analysis. The length of this thesis precludes carrying out this exercise for all the text and all the participants. However such an exercise with comparison across all the participants has the generative and creative capacity to bring up different concepts and discussions not previously established through the use of thematic analysis alone.

It has been intentional to present the ‘text quilts’ of two of the hospital based midwives and two from the community. The purpose is to explore if the context of their working lives reveals any differences in the views. The ones chosen are Pamela, Sally Ann, Mary Dix, and Kerry and these were the order in which the ‘quilts’ were created. [see Figures 8:1]. I fix them on the wall in order to visualize them effectively. Initially I examine each one individually to establish what can be interpreted and then look at all of them together. I will present here some of the information I obtained from ‘playing’ with Pamela’s ‘text quilt’.
Firstly, I look at the text quilt from the front. I note that for Pamela the colour red predominates in the key words around the edge, along with the blue used for current professional issues. This is an indication of a higher focus on physical aspects of being a midwife. This may not be surprising as she is based in a high technological delivery suite.

I then consider the key words around the edge. There is a mixture here of words and phrases related to both personal and professional issues for Pamela.
I decide to look at how they match with their opposite word in the frame. Figure 8:2 shows these pairs, including the corner pairs.

**Figure 8:2: Pamela- Text quilt Opposites**

<table>
<thead>
<tr>
<th>Personal Experience- Need for compassion</th>
<th>Responsibility- mediating changes in society</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional training- Put on a pedestal</td>
<td>Teamwork- Empowering</td>
</tr>
<tr>
<td>Good to have fear- Spiritually linked</td>
<td>Time- Knowing when to intervene</td>
</tr>
<tr>
<td>Devastating memories-Deep connection</td>
<td>Confidence- struggle</td>
</tr>
<tr>
<td>Conflict-Not valued</td>
<td>Belief- Being strong</td>
</tr>
<tr>
<td>Medical team- Unsupported</td>
<td>Essence of being with woman- Being there</td>
</tr>
<tr>
<td>Intuition- caring</td>
<td>Holding fast to normality-Being the constant</td>
</tr>
<tr>
<td>My identity- Making a difference</td>
<td>Giving Support-pressure</td>
</tr>
<tr>
<td>Constrained by family- Trust</td>
<td>Holding fast to normality-fragmented training</td>
</tr>
<tr>
<td>Practical conduct- Safety</td>
<td>Giving—slow to be confident</td>
</tr>
<tr>
<td>Risk management- More than just a job</td>
<td></td>
</tr>
</tbody>
</table>

It is not possible to explore all of these pairs in depth, and I present eight of them here, aiming to include one from each colour grouping. However, the apparent serendipitous spiral placement of the words has led to an interesting pattern in the pairing (See Figure 8:3). In the right-hand column I record my responses, elicited through on the juxtaposition of terms. I recognise individual readers may respond differently and I invite you to consider what for you is stimulated by the material presented in this way?
**Figure 8.3 Pairing of words**

**Personal Experience- Need for compassion**

In this pairing one could relate how the personal experience of this midwife perhaps has led to the recognition of women’s need for compassion in a professional sense.

**Professional training- Put on a pedestal**

This pairing could be interpreted in that the professional training a midwife receives has an impact on her identity, with the feeling that some women may put them on a pedestal of perfection.

**Practical conduct- Safety**

The interpretation here is about recognition that how the midwife conducts the practical aspects of the role has a significant affect on safety for the woman and her baby.

I am touched by these words in seeing that midwives’ own histories and personal lives can be carried into their work places. What about those midwives who are expected to continue working when they had had pregnancy loss or problems with infertility? They need to have compassion too, which is often notoriously lacking in maternity services.

I feel that midwives are seen as being important but also that women see midwives as significant people in their lives. When midwives don’t live up to those expectations then that’s when women become frustrated with the maternity services. Yet there is also reality that midwives are human beings and not perfect all the time. Professional midwifery training thus has the capacity to change people’s lives as it makes them into these ‘paragons of virtue’. This is a big responsibility when thinking of this as an educator.

I recognise here importance of practical skills for midwifery care. Midwives need to know how to stand back and let things happen. However if something is not straightforward she needs to be prepared enough to know what to do and to carry it out effectively in order to protect the mother and the baby from harm.
Devastating memories-Deep connection

In this pairing I see how the feelings about the experiences this midwife has had have an impact on her relationship with women. They have led to recognition of the need for intensity of the relationships. An alternative interpretation is that she is still deeply connected to these devastating memories and these are still impacting on her.

Medical team- Unsupported
This pairing appears to follow on from the last comments where she indicates dissatisfaction with the role the medical team play in supporting midwives in their role.

I recognise again how midwives have personal lives as well and how they carry experiences. These they have to 'switch off' in order to care for women at one of the most significant moments of their lives. The intensity of this connection is, I believe, a choice on the part of the midwife. For Pamela it seems that the memories she has leads to a greater connection. For other midwives it maybe that they will put up a 'wall' and choose not to 'connect' to women in such a deep way. An alternative interpretation is that such 'devastating memories' would still impact. I feel this when considering students who come into training having had difficult birth experiences, and midwives who have had to deal with challenging cases. There is a need to consider how we can effectively support or even 'debrief' these midwives to enable them to 'deal' with their personal circumstances so that they don't impact on their care of others.

I also recognise these problems with professional relationships from my early practice years. Interprofessional education for health care students is aimed toward eradicating these barriers between professionals. However it is not clear whether this is being effective. Attitudes of both the medical team and midwives need to change in order for care for women to be 'joined up' and to meet her needs appropriately.
My identity - Making a difference
Pamela relates here that she recognises that she personally wants to make a difference in her professional role and that this is linked with her personal identity.

Constrained by family - Trust
This pairing provides more of a challenge to interpret. However the indication is that she recognises how the affects of her family life on her role is that she feels there is some impact on her trust of others, or others trust of her.

I feel that the meaning of being a midwife to Pamela is that it is 'who she is', it is her identity and this affects all she does. I resonate with that statement in that I still say I am a midwife in some situations, though not practising always in the way people expect a midwife practices. It still is 'who I am', my identity. I feel too with her desire to 'make a difference'. Perhaps you have to have a 'midwife-as-identity' in order to feel this passion, to leave something worthwhile behind. Or does this personality trait of wanting to make a difference make the role of being a midwife more important personally?

When I started my midwifery training it was unusual for midwives to be working part time. If you wanted to progress in midwifery it was expected it would be in a full time role. Over the years this has changed and a large number of midwives now juggle their midwifery roles with being parents or carers. Working relationships are harder to build when part time as you are no longer working with the same group of people all the time. This affects relationships with the medical team as well who do not 'know' the midwives and their practices as well as their full time compatriots. I can resonate with this concept of balancing family roles and trusting relationships in the professional capacity. There is a need for balance and wholeness in the way a midwife practices.
Holding fast to normality-
Fragmented training
The pairing here illustrates the concerns that there has been a link with changes with education of student midwives here over time and an effect on the role of the midwife in relation to birth.

I resonate with this connection as it reflects the concerns I have had relating to education. Have we ‘lost something’ through modular schemes in Universities? Has it led to this ‘fragmentation’ she mentions? But in addition there is the concept of midwives ‘allowing’ normality to be taken away. The truth is that students have always had 50% of their education in the practice setting, and if there is criticism it could be levelled at clinical midwives not teaching students effectively in normal birth. The fact too that society has changed from the past will have had an effect on women’s health and feelings about birth. We can’t blame it all on education.

The interpretation above gives a different lens through which to interpret what Pamela is saying. However this does not explore all the things she has said. An alternative way of exploring her views is by considering the text in the squares where the different key words meet in the ‘text quilts’ as a creative device to elicit further response in myself. It is not possible to do this for the whole text here. Therefore I have chosen examples. Presentation of the examples is in Figure 8: 4, with the final column demonstrating my spontaneous interpretive responses.
### Figure 8:4 Pamela text quilt interpretation squares

<table>
<thead>
<tr>
<th>Personal Experience</th>
<th>Need for compassion</th>
<th>Practical conduct</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>But they came out of the woodwork, I have to say, ward managers, head managers, they were all up there. It was very fair... But, you can... you can feel let down actually. I think it’s varied, in the last five years...the job is so much more stressful and I don’t necessarily think we’re valued: hideous, hideous six months ago, hideous it was just the worst I have ever known it. I coordinated on delivery suite- it was just , the worst I have ever known, and you hang in there and you just think, where is our manager, where is she, where is she, is she supporting us, you know. RED</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conflict</th>
<th>Teamwork</th>
<th>Empowering</th>
<th>Not valued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the years I have cared for five of my friends: ‘all had normal births which was fabulous experience.’ It ‘really embedded [my] vocation of normal midwifery within me and was a peak experience in my career, especially the birth of my best friend’s daughter. I then had two emergency CS of my own, which were also peak experiences for me</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### In this extract Pamela is talking about a stressful time on her unit. She is not relating this to any personal experience in the past however it could be considered that her past experiences may have an impact on how she reacts in his situation. She is demonstrating a need for midwives to also have compassion and to recognise the stress they are under at times. She is relating the conduct of the coordinator in ensuring safety in a very stressful environment. |

### This extract relates to her personal experiences. She relates ‘fabulous’ normal births for her friends and yet had surgery for her own. Potentially this could lead to conflict with her view of vocation, though it appears all these events were potentially ‘empowering’ for her. It is however a challenge to see where teamwork and not being valued in this quote. |
<table>
<thead>
<tr>
<th>Medical Team</th>
<th>Practical conduct</th>
<th>Safety</th>
<th>Unsupported</th>
</tr>
</thead>
<tbody>
<tr>
<td>But some people don't care about belief - because some people don't feel the same; maybe, some people don't have the same emotional attachment or love or whatever it is.. I think my point was it is more than just a job and you were saying there were people who think midwifery is just a job and sometimes when you say to people that you are a midwife they kind of give you this connotation of you are this, kind of, put you up on a pedestal. It's a bit how valuable a job and how lucky you are to be this or have this profession or how worthwhile this is.</td>
<td>Pamela highlights here that midwifery to her is 'more than just a job'. She relates that some don't have the same attachment to the role, and potentially this could be levelled at medical teams as their training in obstetrics is different to midwifery. Their focus is more on practical conduct and safety. This conflict may make midwives feel unsupported despite the suggestion that midwives are 'put on a pedestal' by some members of the public.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowing when to intervene</th>
<th>Time</th>
<th>Good to have fear</th>
<th>Spiritually linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think it's good to have that fear within yourself, because it's worth having and I have seen it with other people with no fear, and are just really blasé. I think it's what you need to be good. I think it's a fear you have to have to do your job well within your self- I can look confident, I can do it and I am happy, exteriorly I am fine, but always in the back of my mind or in myself I am conscious that it can go wrong</td>
<td>In this extract Pamela is talking that it is 'good to have fear' which serendipitously is one of the matching side headings. Included in the fear is about knowledge of when a midwife needs to intervene and be confident in her skills. It is also having an understanding of the principles of time and when 'time is up'. Fear could also be linked to this midwife's understanding of the spiritual and recognition there is a deep aspect about the fear she has.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being there</td>
<td>Essence is being with woman</td>
<td>Conflict</td>
<td>Not valued</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>I don't think everybody has this experience. It is so much a fabric of everything I have been through in midwifery I think I had very good grounding, very good training. That was really important. I moved hospitals and experience changed there. The experience I had as a midwife made me the midwife I am I think.</td>
<td></td>
<td>DARK BLUE</td>
</tr>
</tbody>
</table>

Pamela recognises that her previous training and experience have impacted on how she practises now. From the headings it could be suggested that she sees the centrality to her experience as 'being there' and 'being with woman', both values that were instilled in her during the training of the 1980-1990's. There may be conflict if other midwives have not got these values and perhaps she would feel these beliefs would not be recognised as valuable by others.

<table>
<thead>
<tr>
<th>Personal Experience</th>
<th>Need for compassion</th>
<th>Confidence</th>
<th>Struggle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I think I am constrained by the short hours that I work – I have to leave at a certain point to collect the children- I have to go- so actually in that short 7-6 hour time frame I think what do I do? Sometimes I don't deliver a baby in the shift- what do I do? Do I just go round and see other people, antenatal admissions, whatever- it doesn't matter what I do, as long as I am helpful and supportive to people I work with.</td>
<td></td>
<td>ORANGE</td>
</tr>
</tbody>
</table>

Pamela here is relating the complexities of her role as parent versus being a midwife. This is a struggle at times. However she recognises a need for compassion for the people she works with and has the confidence in her abilities to provide that support.
**More than just a job** | **Risk Management** | **Unsupported** | **Medical Team** | **Cos I really believe in normality and promoting that and that's so important in the rising intervention rates and the rising inductions and rising sections and yet we don't seem to have time or we don't seem to have a place to say because sometimes women are in the middle. **LIGHT BLUE** | **Pamela relates here her belief in the importance of 'normal' childbirth, as midwifery is 'more than just a job' and concerns about intervention. The underlying implication could be the role of risk management, and lack of support from the medical team.**

| **Safety** | **Practical conduct** | **Giving** | **Slow to be confident** | **I think I would find it very difficult to be a student, I think it's very fragmented. There is no latch on to one mentor and be with them for the whole time, that's gone, that's well gone and that's affected their training. It takes them a long time to be confident, and it's very stressful. [In relation to the length of training] I think it's the chicken and the egg ...because I had nursing behind me and huge experiences in that, good, bad, life, death** **GREEN** | **Pamela is relating concerns here about current student training and that they are 'slower to be confident'. This has a relationship to practical conduct and the appropriate safety for the women. In relation to giving I would interpret that Pamela has to give more to the students in order to help them to be confident.**

| **Confidence** | **Struggle** | **Unsupported** | **Medical Team** | **The first picture Pamela made falls in line with confidence. This is significant as Pamela drew her hand as important for her as a midwife. Confidence in her practical and comforting skills are relevant. However it remains a struggle for her to provide this comfort and protection for** | ****
mother and baby and once more being unsupported and the affect of the medical team may come into it

<table>
<thead>
<tr>
<th>Hold fast to normality</th>
<th>Caring</th>
<th>Being the constant</th>
<th>Intuition</th>
</tr>
</thead>
</table>

Pamela's second picture illustrates the division between 'normal' and medicalised care and the words here all refer to the 'normal' side of that division. It could be interpreted from this that these are the keys to midwifery for Pamela.
As indicated previously the above text demonstrates how the text quilts could be interpreted individually. In addition the text quilts could be examined on a macro level to provide a wider visual view.

8:3:2 Looking at all four text quilts together

I decide to place all the quilts on the wall in order of the time I had made them and view them together.

I am struck by Pamela’s quilt being much smaller than the others, which indicates she used fewer words in her discussions. The quilts therefore do not map together evenly or equally. This demonstrates vividly the individuality of each person. I am struck too by the different colours that come through. Kerry and Sally Ann, based in the community show more purple based squares (related to spiritual/meaningful issues). Kerry shows particularly many yellow based squares (related to social issues), which is a reflection of her intense views of the public health role of the midwife. Pamela’s quilt is predominately red, with a focus on practical, while Mary
Dix has a number of pink, emotionally based squares as well as mainly blue (related to current professional issues). Just by examining from a distance gives an element of comparison between the participants.

Interpretation can also be made of the points where the text quilts meet.

The juxtaposition of the quilts provides a different viewpoint, which may be changed as each is rotated and shows a different face to the other. If these quilts are viewed as a whole person the faces of each will interact and react with others ‘faces’ they meet on a frequent basis. In addition they will be constantly changing and evolving. Illustrating the quilts in this way thus demonstrates further the multi-dimensionality of each person that would not be recognised through the conventional fracturing of interviews by thematic analysis. The quilts also demonstrate a mixture of the personal and professional, which is also reflected in the textile quilt that I am crafting.

January 15th 2009 (I have shown a text quilt to my EdD group)

[name removed] comments on validity that ‘if it gels right for me’ then it is valid and that it ‘fits’ with the holistic a/r/tography paradigm. The challenge remains how I write this up; how I discuss the material in an appropriate way-
how much time I have etc. Not helped by all that is going on in my head! [another name] suggestion to look at it from down low or side-ways and see what hits you from a different view is great! I like that a lot!

*Figure 8:5 Kerry’s text quilt from different angles*

Looking at the text quilts from different views provides a multiplicity of angles to interpret from and demonstrates that there are contours within the framework, that each person is three (or four) dimensional as opposed to being a flat, piece of paper or a statement of words.

Creating text quilts in this way provides a multiplicity of dimensions to look at data and enables a sense of freedom and creativity that words on their own in qualitative research do not do. This freedom is reflected in the continuation of the above entry in my diary:
January 15th 2009 part 2

Funny moment - at the end of the session as I scraible in my bag for a key I pull out a plastic green door from the children’s Happy land. It is symbolic to me that, whereas I have had black, shut doors, that this is not only colourful, it is also a door without walls- so therefore permanently open. Not only can I step through it but step round it.

8:3:3 Asking the midwives their views

In accordance with my aims to validate the material created I sent the midwives copies of their vignettes and the completed text quilts for response. Three responded: one verbally, stopping me in a corridor. She said she had been too busy to complete a response but that she was amazed at the information and wondered how I would gain anything from her story. Another responded by writing how much she had enjoyed being part of the study. The third gave an extensive response. She stated that it had surprised her how negative she was and could not remember what she had said. She felt it was:

interesting to see ‘me’ unfold in a quilt. Some of it I’d like to take back, but can’t cos it’s there in front of me.

She felt that:

the outer ‘connectives’ on the ‘quilt’ encapsulate being a midwife and working in today’s NHS.

She also felt the quilt method, though new was:

very valuable- nice to have it to look at, perhaps not nice to have it- to see raw material close to the bone- can’t really ignore, cos it’s there in front of me- very visually and very colourfully

Her final comments relate to suggesting I market these as personalised puzzles, where individuals have to face themselves. Her comments indicate the quilt as a visual tool also stimulates an individual response.
8: 4 Thematic analysis: meanings of being a midwife

In order to answer the questions it feels appropriate to examine the material using thematic analysis to evaluate emerging themes across the words of the midwives. This is a common method used within qualitative interview studies (Anderson 2007) relating to reducing the data to a manageable amount by deciding which sections are relevant to the initial aim of the study (Silverman 2010:234). My feelings about doing this are mixed. On one level, as the aim was to keep the participants as ‘whole’ as possible in presentation of their words, I feel some discomfort in dissecting their thoughts out of context of the individual. However, when evaluating the midwives’ vignettes it becomes clear that there are some similarities in their comments, and some differences.

I decide to use an organic approach to the interpretation, as this appears appropriate to recognising the link of myself to this study.

Where most qualitative research insists that the researcher identify and bracket her or his assumptions and presuppositions to achieve a state that is free of personal judgment, organic inquiry depends on the researcher’s ability to hold her or his personal experience, both of the topic and of the progress of the research itself, in the foreground as the data are gathered and analyzed and to consciously use it as the vehicle for analysis of the data (Clements et al 1998:1).

I consider my reflexive approach with the quilting is part of this organic inquiry and therefore will also need this to be entwined within the interpretations.

In keeping with aiming to explore the issues from an holistic perspective I decide to examine the vignettes through the lenses of the suggested elements of holistic care, physical, psychological, spiritual, and social, recognising that such action is ‘reductionist’ and decries my belief that these aspects also interact with each other and are not isolated from other individuals, including myself as researcher (Goddard 1995, McSherry 2006:73).

27th January 2008

Our eldest is deep in textiles work. There is beauty in the work she is doing, and yet there is beauty too in the scattered parts around her that she is discarding. They are going to be binned, but instead I gather some of them.

---

1 Based on the original work of Miles and Huberman 1984
consider the issue of discarding something, the different parts that don't meet the needs at that moment. I am seeing this in analysis that I am going to have to discard things- to choose what is not right and beautiful for that moment- in order to focus on the issue that calls for attention.

8:4:1 The essence of a midwife

As discussed in previous sections midwifery in the UK has been in a process of change over the past thirty years. Changes in structure of the National Health Service, governing bodies, and education, have impacted on the lives of midwives at the clinical face of the profession. Continued moves to ‘professionalise’ midwifery (Sandall 1995) and raise its status has led to changes in management structures as well as a ‘risk management’ agenda supposedly based on ‘evidence’ that could be challenged as being appropriate for individualised care (Walsh et al 2008, Henley-Einion 2009).

Personal significance

This group of midwives have been part of this change process for many years, and therefore provide a valuable insight into their perceptions of the role. Yet, despite these changes, there is a strong sense that there are deeper meanings for them remaining as midwives, as opposed to it being just a career path.

Connie (H): I think for me there are natural midwives and there are people that practise midwifery and do a qualification …but just to talk about normal things made me reflect on the fact that I think I am a midwife by birth, if you like, that was what I was meant to do… for me it’s not just about the act of birth, it’s a bigger picture and it always has been.

Lizzie(H): I think it is a vocation…and there is some sort of calling there.
I don’t think everyone can be a midwife. I mean there’s a mixture of people who are midwives, we are not all cast out of the same mould … I think it’s something you either can do or you can’t so I think it’s the only way I can describe ‘calling’. It’s, you know, perhaps it’s a need as well. You have a need to do it in some ways. (laughter)

This ‘calling’ was identified by all the participants in Carmen Linhares (2007) study relating to the spirituality of childbirth. I am challenged by Lizzie’s view that midwives have to ‘need’ the role. The indication here is that being a midwife is ‘for the midwife’ as much as it is for the clients in her care. Lizzie’s view is expressed further by Pamela who states midwifery is ‘who she is’.

Pamela(H): I believe that I make a difference to the people I work with, the women, the atmosphere. Being a midwife is my identity; it’s what I do/am.

The view she expresses is deeper than a ‘professional identity’ that is corporate but is more related to her ‘personal identity’. This stance is agreed by Lucy who suggests that for some midwives this ‘added’ component is not there.

Lucy(C): I don’t think it is a job, I think it’s…more than a profession, it’s something within you that helps you to be this person for a short period of time that you are with the individuals. I suspect you probably can practise without this ‘something’ because, if you’ve got the mind to, we can probably do most things in life if we have the right sort of training and sort of knowledge base but perhaps it’s the ‘something within you’ that makes people say to you how much they’ve enjoyed knowing you and, how helpful you’ve been and that sort of thing.

However Jennifer sees being a midwife as being an ‘actress’, as being a ‘different person’.

J-A( H): But who really knows the real you? You could be an actress [personal story removed] We’ve got this professional persona as well and we would giggle and go ‘hi how are you?’ and you can solve all your problems and you just put a face on it because that’s your job…so we do
a lot of that, some of us need Oscars don’t we?[laugh]…

The concept of ‘acting’ or ‘hiding feelings’ have been recorded elsewhere (Anon 2010a, Bewley 2010:200). Such comments have implications for selection of future midwives and education.

For these midwives the identity of ‘being a midwife’ is clearly significant to them. The word ‘privilege’ is used.

J-A(H): I love my job and feel privileged to do it.

Kerry(C): I am still a midwife because I love the job I do. It is a privilege to care for women at such a special time in their life. I still learn something new each day.

For others it is a rewarding profession.

Archie (H): In this situation it still is the best job in the world and I still enjoy every day that I’m in, even under those circumstances.

Lucy(C): I am still a midwife because it is a fab job and rewarding.

The concept of midwifery ‘giving rewards’ back to the midwife is perhaps not surprising in the sense of understanding ‘vocation’ as an altruistic role. Altruism, ‘a self-less caring for others’ (Koenig 2005:62) appears to have a positive effect on mental wellbeing of the giver (p62-64) and the principles of ‘giving and receiving’.

Mary D and Pamela recognise this feeling of being valued by others outside the profession.

Mary D (H): I feel being a midwife has a certain ‘kudos’ among the general public and I have a certain pride in belonging to the profession

Pamela (H): …it is more than just a job… sometimes when you say to people that you are a midwife they kind of… put you up on a pedestal.
This is in contrast to perceptions that the media portray midwifery currently in a very negative light.

Archie (H): *I think it’s because you see it in the papers don’t you …also the television programmes have not done us much good, they’ve portrayed the midwifery services partly as they are. I can’t deny it’s not the truth and it obviously is the truth in those hospitals.*

Lucy (C): *Particularly if you pick up any Sunday paper over the last 6 to 8 months for example there’s been huge things in about women giving birth with no midwives in attendance and things like that…it makes me cross…because the way it’s written generalises…But unfortunately if you were pregnant and you were reading something like that you would be mortified. I don’t think…the people who are writing these things are helping [our profession] at all…*

Clearly these midwives are concerned at how the profession is portrayed as a whole as it is so important to them.

**The type of midwife you are**

These midwives indicated there were differences in the types of midwives in the profession. For example Connie relates:

Connie (H): *I think for me the art of midwifery is very much you are given it, it’s there, it’s in with you… I think some people can learn it by being with other people but for some people I think it’s something they never achieve and they will always be practising midwives rather than midwives with an inbuilt skill to give good midwifery care and I don’t think it makes them bad midwives, I just think it makes them different midwives.*

In contrast Jennifer suggests that there are conflicting views of self-importance in midwives who work in different areas.

J-A (H): *…there is… still a gap between the hospital midwives and the community midwives and how the hospital midwives view themselves*
and delivery suite midwives [especially]… they think…, it's all about who can stand up to the doctors more… some of the delivery suite midwives who have been there a while think oh this is the best job in the world because we're more important than anyone else- but we're not, absolutely not.

The ‘us and them’ issues between midwives in different roles are not unusual and are also recognised through hierarchical relationships (Hunter 2005, Pollard 2005, Begley 2002). Competing ideologies also leads to debates between independent and hospital based midwives. The impression is therefore of a profession that is somewhat divided and in conflict within itself. Conflict also arises in the individual midwife. Archie, when creating her picture with photographs highlighted a division in the midwifery she was practising and the midwife she would like to be.

Archie (H): it just jumped out at me at the two very different sides of midwifery today and how I feel as a midwife. So what I've done is one side of midwifery, which is the hospital based in charge midwife which is what I am [laughs] and the midwife I can sometimes still be and that I’d dearly like to be which is the midwife in the true sense… I feel that the job has become quite divided…

Sally-Ann feels there should be two different types of midwife.

S-A(C): There is definitely potential for [two different types of midwife]... I think there are lots of midwives, certainly the community midwives that I work with, who have been very anxious about going back to the biomedical side of things…to the delivery suite- and when we first started discussing rotating into the birth unit and the midwifery led side of things they were…very concerned and a lot of them …leaving the profession, just because of the anxiety…there are a lot of midwives that work in delivery suite that enjoy the high dependency side of things especially that they seem to be predominately nurse trained midwives… I'm not saying that all Direct entry midwives would want to steer toward the normality side, I am sure you must get a mixture…, I think that you will get that division- I suppose it's just natural that you will get midwives that [are different]
The suggestion that midwives trained as nurses first may be content to work in a hospital environment is not known through statistics. However, it appears that those who work in hospitals remain keen to have students who have previously been nurses.

Jennifer suggests that there is a difference in the way she works in the role of manager of a busy high technological unit.

J-A (H): There are two types of midwives, aren’t there? There are hundreds of types of midwives… one minute I want to be known as this really in control woman that can run delivery suite that everybody respects, I’m approachable, I’m knowledgeable and that’s what I want to achieve, but when I go into a room I can give a woman warmth and love and attention, and there’s conflict coz some nights I can’t do that. The being with women side is more the art and the managing running delivery suite is more the scientific definitely, definitely, because they are two very different midwives aren’t they?

The implications of suggesting there are two types of midwives reflects discussions that have been taking place around midwives versus obstetric nurses that have been continuing for many years. However all of these midwives have worked in community based situations at some time in their career and recognised the significance of that area. If they are suggesting there are two ‘types’ they are suggesting that they can move between context and carry the ‘art’ of midwifery with them. There appears to be adaptation of the ‘art’ as required.

Pamela continues:

Pamela (H): …I suppose what it means to me and what it means to a lot of people … it’s more than just clocking in and clocking out. It’s fundamentally making sure you want to see that mother ok and that baby ok… To some degree the experience they had to get there might be a bit of a lesser point, but just to make sure that they are alive and that baby is alive, is kind of what’s with you when you go out of the door… it’s safety really predominantly. It is not just where I am working
at the moment. I could be working at a home birth and think the same.

For Pamela it appears that the meaning of the role lies in the depth of personal responsibility she has to the family she is caring for. Connie is also aware of the significance of her role in keeping women and babies safe.

Connie (H): They come to us to have a baby and to go home as a family unit so keeping them safe for me is the most important thing. How their babies deliver is not. I don’t feel that it has to be vaginal birth against everything else to feel that you have succeeded.

The concepts of ‘safety’ and ‘risk’ have become big buzz words in the maternity services of the UK in recent years. Alyson Henley-Einion (2009:184) states:

Reduction of risk is aligned with cost reduction, and quality with standards, the experience of the individual, particularly of the woman giving birth is invisible.

For these hospital based midwives the safety of the mother and baby is high priority. On reflecting on this I am concerned about the way safety is leading to anxiety and fear in professionals and women. Anxiety affects the balance of the hormonal responses which, in turn may lead to more delay and problems during birth (Buckley 2005). The indication is that the prioritisation of safety above other values by these midwives may impact instead on the delicate balance of labour.

Importance of the impact of the role

It is known that women have powerful memories of their experience of pregnancy and birth in relation to the midwives who cared for them that may have a long term effect on them (Belenky et al 1996, Simkin 1990, 1992). In this study the midwives found a meaning and purpose in midwifery having an impact on the women and families in their care, of wanting to be valued.

Lizzie (H): You do make an impact. It’s amazing the number of women will remember, most women will remember their deliveries whether they are good or bad. If it’s good it’s positive but they will always remember the bad things as well.
There is significance in this as the technological interventions continue to rise and women and midwives are having less opportunity to spend time together to provide this type of care.

Sally-Ann feels her role as community midwife could be overlooked, despite having invested in the relationship with a woman,

S-A (C) … although they spend much longer time with these women during their pregnancies, the community midwife is almost forgotten … I’m not saying that you expect cards and gifts, but the vast majority of time it’s the midwives who’ve delivered the babies or the short time that they are in hospital that gets the thanks…so I’d like to think…that these ladies remember me for the right reasons and hopefully the memory of me will last longer than perhaps just that short time during the birth process itself.

For Kerry, in order to feel that her role was still worthwhile as a community based midwife, she chose to move areas from working with relatively wealthy, well-educated women to one where the social needs are greater.

Kerry(C): The art of midwifery is connected with happiness about where I am yes and I think you have more of an idea of people’s lives when you are in their homes, meeting their friends, meeting their family, than you could argue going into delivery suite delivering and then coming home again so for me that has the biggest job satisfaction. …

She continues by recognising the importance to her of being there for women during antenatal appointments.

Kerry(C) : I suppose it’s wanting to feel special as a midwife in their life as well and that’s very selfish to think that but these women coming in for their 15 minute appointments that’s their 15 minutes of no other children, no husband, that’s devoted to them and their growing bump and that special time and feeling it and asking about the baby movement and them talking about yes he does this and he does that and he’s active at that stage, so they’re engaging with their bump and their baby,
and you know they might not get that through the day…I suppose that ranges from…the most educated person and most upper class person to the very socially disadvantaged person. They’re all coming in, hands on tummy; yes my baby is moving and this is happened and that’s happened. I suppose what I’m saying I prefer to work in the socially disadvantaged group but for all women it’s the same recognition of their baby and their growing bump.

These community-based midwives want to feel valued by the women and recognise how their presence with them in the women’s pregnancy can have an impact on them. This has also been identified in research exploring reciprocity of relationships between women and community based midwives where:

the concept of reciprocity seems to provide a useful analytical tool for understanding why some midwife-woman encounters are experienced as balanced and thus emotionally rewarding for midwives, whereas others are experienced as out of balance and emotionally difficult. (Hunter 2006:19).

This is of importance where current reduction of funding of services is giving midwives less time to spend with individual women providing care. This could lead to midwives feeling less valued as there is a loss in the ability to form meaningful relationships.

However the intensity of the relationships described is in conflict with Nicky Leap’s (2010:8-10) assertion that the role of the community midwife should be to promote other relationships for women, ‘community’ and not solely that with the midwife. The hospital-based midwives, in contrast, talk about wanting to ‘make a difference’:

Connie (H): I am still a midwife because I still enjoy it and because I can make a difference.

Pamela (H): The essence of what I am as a midwife is being with woman at normal birth- don’t take that away from me thanks. I get up in the morning to think I am going to work …purely, not whether I have x-many deliveries that day…I go to think I make a difference, and if I didn’t think I made a difference I wouldn’t bother going…It’s not exactly to the women; I mean it’s not just about giving it, giving it, making a difference
to women. It’s making a difference to my colleagues, and I think, oh yeah, we had a good shift today, when I was on, I maybe helped that.

There appear to be some differences here in that the hospital based midwives want to be seen to be change agents in the work place, an altruistic way of being, and perhaps of ‘doing’. Whereas for the community midwives personal relationship with the woman gives the midwives themselves value. The potential may be that different ‘types of personality’ are choosing different places of working.

Archie indicates how personality of the midwife can make an impact on the woman in the delivery suite.

Archie (H)... when you walk in you have no idea about anything about that woman when you first meet them... And you change as well as you get to know that person...because you know how much they will allow you in, whether they might not, what their background is. I mean..., practical skills are affected as well by the way that you are...whether you are busy-bodying around them. You can be very formal...or you can be quite relaxing and calming to them... It depends on how busy you are. It also depends on personality which is a huge amount I think.

Archie was also critical of the behaviour of midwives in the hospital birth areas, and the impact this could have.

Archie (H): I think there are some who don’t have the skills of the art.... I think some people are very harsh...and I think midwifery is something that you have to have a lot of compassion in. It’s a very intimate job, so you have to be very careful how you conduct yourself. And some midwives...[are] not quite in tune with the woman they are with. And I also think that can affect the labour.

Other research has identified that some midwives do not demonstrate this attitude of kindness or care (Halldorsdottir & Karlsdottir 1996). The midwives here state that they want to make an impact in their role, whether it’s on the women themselves or with their colleagues. Whether they achieve this may be a result of their personalities or the quality of compassion.
8:4:2 The art of practice

For these midwives the essence of being a midwife lay in the ‘art’ of practice. In this context women-centred, individualised care is significant as well as the belief in ‘normality’

Holistic and individualised care

Midwifery in the UK is expected to be within the context of women-centred, whole person care (NMC 2009). It is therefore not surprising that the midwives, specifically those in the community, equate the art of midwifery to holistic care. For midwives who have worked in the community holistic care is connected to the social context of the woman.

Kerry(C): Holistically is just looking how pregnancy impacts on a woman not just the obvious physical attributes of a pregnancy but how it might impact her socially. You know, with her job, coz career for a first time pregnant woman is a huge part and so take the career away from the woman and how that impacts on her life. If they’ve got other children and what that means for the other children in exploring that… …In other ways holistically I suppose is the psychological, mental attributes that you can have in a woman and just the sheer celebration of this amazing thing that’s happening to them.

S-A(C) Holistic means the whole, not taking the woman in isolation. You need to look at her in her family setting- her as a whole person, not just her physical wellbeing, her mental wellbeing, her social status and as a midwife you cannot build a proper relationship with a woman unless you understand where she’s coming from and what makes her the person that she is…a large part of midwifery I feel is that you need to build a trusting two way relationship with the woman and without that you are really not going anywhere, you are not going to achieve anything, not if you want a truly holistic type of care.

Lizzie states that holistic care is about recognising that pregnancy, birth and postnatal care are all relevant to each other.
Lizzie (H): They all interlink, the holistic approach of midwifery; if you are looking at it antenatally you are just following a pathway and you are trying to have a pathway from one stage into the other and they all interlink because antenatally as a woman progresses in pregnancy you are preparing her for the labour and trying to prepare for the postnatal…

Other hospital based midwives suggest holistic care is more difficult to carry out in a hospital setting, where care tends to be more fragmented.

Connie (H): I would say that it is very hard to provide holistic care in the current climate of the NHS and the delivery suite forum… I think that you can to a certain level give holistic care when you are giving one to one care on a delivery suite if you have the skills to provide midwifery care that is actually fitting what these parents want…what the pregnancy is dictating you. If you have someone that is very unwell or has complications it sometimes is hard to give the whole package that you would like to give to someone who is low risk.

Lizzie (H): What I was talking about is looking at a person as a whole. You know their attitude, their general wellbeing, their relationship with their birthing partner, their relationship to you, whether they’re scared… perhaps having a little bit of insight into their background, whether they have had children before, getting their history their experiences. Looking at midwifery from a midwife point of view… I suppose you are looking at the antenatal and the intrapartum and the postnatal. But I have to say that I was focusing on the woman. I think when you are in with the woman in labour you are focusing just particularly at that time and place that they are whole at that time.

Lizzie indicates that holistic care as a midwife in the labour area involves total commitment to the individual woman for that time. However, in an ideal situation the midwives suggest the best form of whole person care is provided in the community setting as they are able to recognise and meet women’s needs in a more complete way. It is clear though that these experienced hospital midwives recognise that labour and birth is not in isolation to the rest of the woman’s pregnancy and attempt to meet their ‘whole’ needs for that time. Lucy also recognises the individuality of
midwives as well as women and the need for flexibility.

Lucy (C): Midwives and clients are all individual. Midwives who provide individual care need to be creative and adaptable to ensure ‘tailor-made’ care for individuals. Some clients may need ‘more’ art than others.

Her comment that some clients may need ‘more art’ is indication that individualised care needs to be flexible to the individual’s needs. This may be more of a challenge in the current NHS environment where midwives are expected to adhere to guidelines that may put restrictive boundaries on their practice.

A belief in normality

In recent years midwifery in the UK has been part of an international move to reduce medicalised interventions and increase ‘normal’ birth (eg Downe 2008, Johanson et al 2002). This group of midwives had recently been part of a module to ‘promote’ normality. Therefore it is perhaps not surprising that the midwives linked discussion around the art of midwifery with normality.

Lucy (C): I think the normal side is more about the art of midwifery yes. Even if it’s not, it’s bound in somewhere...

However they clearly stated that the art of midwifery was not medical care.

Kerry (C) don’t think the doctors, medical are to do with the art of midwifery

J-A (H): The art of midwifery is about delivering the woman, about supporting the women, it’s not about this, [pointing at technological pictures] definitely not- I would consider this is more the science isn’t it?

Mary Dix is adamant that the art of midwifery is about normal birth.

Mary D (H): People who are caring for women not having a normal birth are not using what I would regard as the true meaning of the art of midwifery. You are still … supporting within what you are doing, yes, you are caring for that woman in labour be it an abnormal labour, yes of course you are, and you are still using your skills, but in a different way
than if you were completely autonomous and the woman was having a natural birth that you were managing.

Pamela talks about the fundamentals of the art of midwifery as a belief in birth and relationship with the woman.

Pamela(H): I think the art of midwifery is being with them, [the women] and supporting them, empowering them to believe in themselves, believe in their ability to have a normal birth… that’s what the basics of all this is really, in hoping that she believes, a belief in instilling a belief in her you can do this, whether this is with medication or without medication, …and if they trust you and believe in you and are confident with you then this can really help the experience of normality.

Such a belief that the normality of the birthing experience and the art of midwifery are intrinsically linked is significant as care is becoming increasingly ordered, technological and medicalised in the UK. If this is the case then the art of midwifery is being lost. However the midwives also talked about how the art and science of midwifery interact.

Mary D (H): The science is necessary due to the high risk pregnancy and labour, that's got to be, but I think it goes off hand in hand with the art of midwifery still.

Lizzie (H): …we’re developing different arts. I mean I always used to think perhaps…the art of midwifery being a normal skill, a normal art but I think our arts and skills are developing into the complex side and how we are having to adapt our skills to give people the most normal experience that they possibly can for them, individualising the care. I think we are developing an art because it’s becoming more the norm… If you work on a completely normal…birth suite you are not going to get the medical issues, so if you are working on a complicated or a consultant unit… your art of midwifery is adapted, …For example…a vaginal delivery with an epidural, I think that’s an art, and monitoring it. I think using syntocinon². There are some people that still don’t get the

---

² A synthetic hormone used to stimulate contractions in labour.
These comments on the art of caring for women with complications are repeated by others.

Connie (H): I think it’s because people with complications they become the complication, … and your care is very focussed on the medical problem of that time and so just by the virtue of the care you are delivering… I think you can make something quite complicated normal if its handled appropriately…

Archie (H): There’s art in both sides...because the technological side you can’t ever get away from it. I mean for years unfortunately there will be problems with childbirth...there are still going to be problems... things do go wrong... if you’ve got a preterm lady in labour then there’s a huge art there... maybe even more of an art because this lovely part of midwifery is usually the straightforward part isn’t it?... ...

Both of these midwives are hospital based. It is therefore interesting to hear community based midwives also expressing similar views.

Sally-Ann (C): I think... even if you work on delivery suite and even if you do tend to go towards the high dependency side of things, you still need that art of midwifery, because you are still working with women and their families so it’s not just that biomedical side of things; there is also the psychological side of things, that relationship with the women coz the actual birth process itself is such a small part of the actual whole process... Even as a community midwife you still need to know the science of midwifery, you still need the knowledge. In fact out on community sometimes I think you have to rely on those skills even more because the buck stops with you; you need to know when to refer people on... when things aren’t following the norm.

Lucy (C): I see the role of the community midwife as very much being able to accept that not everybody has everything, not everybody is low risk and can have everything ‘normal’… but at the same time even ladies...
who need caesarean section for whatever reason can be promoted to be normal in other manners by trying to encourage them to think about …whether their expectations are realistic and just sort of asking questions to try and make them consider other choices which in a way goes back to…promoting their self-esteem and their self-belief and their healthy behaviour. …

The implications here are that the midwives are recognising the development of ‘new art’ where midwives are adapting their skills to meet an increasing technology. However they still imply that the ‘art’ is connected to normality. The implications for education lie in ensuring students are developing the ability to use the ‘art’ of midwifery in these high technological settings as well as developing the more scientific skills.

8:4:3 The physical aspects of midwifery

The role of being a midwife is ‘physical’ in that midwives use their own bodies actively on a daily basis and also in the intimacy with women’s bodies. These midwives discussed some of the physical aspects of their role.

Personal physical reactions

With the active nature of the role, it is perhaps not surprising that the midwives mentioned bodily manifestations in relation to being a midwife, particularly in a busy hospital birth area. Mary Dix finds a physical thrill in this place of working.

Mary D (H): I think, you need bigger challenges sometimes don’t you and that’s when it’s really busy and you really have your back against the wall, and that’s where I find I get the buzz, getting things coordinated and keeping staff supported and just generally make it work, its safe and people still get to the best of your ability, the care.

However, she does relate that this maybe more stressful for the midwife.

Mary D (H): The medicalised side can be more of a hassle…it’s a more stressful side.
Connie also appears to need this sense of excitement in order to feel she is being stretched outside her ‘comfort zone’.

Connie (H): for a period of time I remember being a little bit in the wilderness, feeling I have not got that adrenaline buzz any more, I don’t get that rush when the emergency bell goes or if I go into a situation that is unexpected I don’t get that heart racing adrenaline buzz that makes you drop things and makes you not necessarily do what you think you do … that was quite hard for a while cause I thought I’d lost it, I felt I’m not getting the buzz, what’s wrong with me? And I think I’ve come to consider is….I have reached a point I am ok with what I am doing, I know my parameters, I know what I am good at and I don’t need palpitations to make me better [laughter]… but I don’t think I have become complacent, I think it’s just I am happy with where I am and that’s ok isn’t it?

Connie recognises her body tells her where her limits are. From her community position Kerry recognises that she felt this excitement prior to her midwifery career and that midwives in hospital units are more likely to experience the physical aspects.

Kerry(C): Being an ex-NICU nurse I was full-on adrenaline, the drama you know, driving on that and I thought, moving into midwifery…we wouldn’t get that adrenaline buzz … I thought I would miss that buzz. But you get it in different ways and I suppose those working on high-tech delivery suite I think…they’re caught up in the adrenaline and the technology of it all. Which isn’t wrong at all, you know, if we didn’t have those people then our sick women wouldn’t be getting through.

Connie addresses physical manifestations she experiences when there are challenging situations where women and babies are becoming unwell.

Connie (H):….on the safety, at that point I feel myself physically changing in as much I can feel my attitude changing…I will be much more business like about certain things because I need them to appreciate
that actually this is important and you get this done. Whereas I might spend an hour discussing examinations and induction and prostins\(^3\), when you are that unwell and your blood pressure is 198 over 110 there is no discussion. You are going to have to give certain aspects of care so you tend to be a little bit more, I don't think brusque is the word, but more to the point about certain things to clarify so not so much time.

She addresses the issues of control in this statement and the need for professional ‘action’. The judgments that are required here in order to get this right in the eyes of the women, her partner and for the baby are significant for midwives.

There is a close balance between this physical excitement and feelings of anxiety and stress. Balance is required in life to allow the physical body to return to ‘normal’. There is only so much a person can take of these ‘highs’ and the need for ‘down-time’. Pamela sees the role as stressful.

Pamela (H): … I think you have to have a lot of belief to do it, because it’s very stressful and if you thought long and hard about what you do, no money in the world pays you for that; blood rushing to your feet moments, no money pays you for that.

For Connie too the physical demands of the role are significant, which leads to emotional response.

Connie (H): I think a big part is that we are physically tired at the end of our shifts and…that sometimes gets you before anything else. You’ll see tears, you’ll feel tearful yourself and somebody may say the wrong thing to you…. It’s just that you are incredibly tired. It’s a physically demanding job.

Jennifer takes this further by addressing midwives being women ‘of a certain age’, suggesting hormonal responses maybe having an effect.

J-A(H): And sometimes you think no, no you’re being ridiculous, but unfortunately most of us are 40 something and there’s a lot of problems

\(^3\) A drug used to stimulate labour.
really and it...definitely affects your thinking and... some days people don't see me as this sort of person, but I am really, really sensitive and I'm very, um, in a hyper state of reactions to how people react to me and...some days you'll go in and think did she not smile at me then? Did she not say hello? And it isn't them at all, it's you. Its where you are, how you feel, and hormones govern you completely; I feel sick and you're thinking oh, is she not friendly or you go in another day and you just laugh all night...it's being a woman.

I smile at this statement of 'it's being a woman'. So few male midwives are in practice it is difficult to judge whether this is about midwives in general or the fact that midwives are women that means the physical reactions are enhanced. When it is considered that a large percentage of midwives are in the age bracket 45-59 (Midwifery 2020 Workforce and workstream report 2010) there is potential that there are many whose physical changes are affecting their midwifery role.

**Physical Working environment**

Many of the comments related to the physical aspects of being a midwife were in relation to the environment of practice. Archie describes the environment of the pool room.

Archie (H): *I love doing water births in the unit now because shut away in that little room...that's a lovely environment to give birth in and I love it when it's just the midwife and the couple or just the woman because you can give them everything and that is humbling to watch a birth in that situation and this is...the difference between the theatre situation or even the delivery suite situation...this is such a new world, a totally different world. That's the way it should be, the way it was intended. So I do find that really deep and spiritual, water birth particularly."

Her picture here of 'being shut away' is indicative of the need for a quiet space to give birth (Odent 2001) but it's also a place where the midwife can feel intimate and able to 'give everything' which is more challenging when she is being pulled out to care for more than one woman on a busy delivery suite.
Jennifer is more critical about the lack of a ‘bed’ in the birth centre but recognises that this environment, and the nature of the birth it brings, gives her fulfilment as a midwife.

J-A(H): I must admit when I go round to the birth suite I think oh it’s so nice round here but I never get a chance to work round there...And it does sometimes make me laugh, coz I don’t agree with no bed in the room...they are useful to lean on…I see the women sitting on the floor in a semi-recumbent position and I think why…it’s all about moving about or whatever, but she could sit like that on the bed which would be an easier working height for you...but I do like the birth suite, I like the pool room- I think it’s beautiful…and the lights, and the lavender and I love the ‘hippy’ music…and those are the days when you are coordinating…you’ve had a couple of emergencies and they’ve dealt with them well, and you pat yourself on the back and ‘yeah that was good-you did good there’.

It is interesting to think how the beauty of the environment can affect the working practices of the midwife.

The midwives also indicate that a birth suite environment enables more demonstration of the art of midwifery.

Mary D (H): I suppose the art of midwifery takes place more in the birth suite than in the main bit: I suppose most of the clients in the birth suite experience, yes, the art of midwifery in its truest form. But that is not to say that we do get clients, it does still happen on the consultant unit but less so.

Archie describes how midwives in the delivery suite physically try to make the environment more like the birth suite.

Archie (H): I am not saying you can’t have a normal delivery up here because you do and you can make that really very welcoming. In fact what we do up this end is bring round the lovely balls...and dim the

---

4 These are large gym balls that women use to support themselves and move on during labour
lighting and we’ve thrown lavender oil\(^5\) in the suite as well so we try to make that ethos come round there. But somehow they still have the accountability of the labour ward… they’re not left alone as much.

The physical environment of birth to be welcoming and even smelling nice is viewed as important (Newburn & Singh 2003). Jennifer suggests that the whole unit should become a ‘birth suite’ environment.

\[\text{J-A (H):} \quad \text{… in the current medicalised approach to delivery suite I feel the art of midwifery is disappearing but very much alive and kicking in the birth suite, lovely yes…It is environment. We are trying to look at things, we’re desperate to bring down our caesarean section rate but you go there and you hit one of those wind chimes on your head and it goes tinkle, tinkle, and that’s nice. And they’ve got little water fountain and that’s nice …it’s the culture of the midwives that needs to change not the culture of the flipping bed being in the room;…I think the birth suite midwives are absolutely brilliant at doing it, they are amazing, and they’re committed, is make the whole place a birth suite.}\]

She indicates here that the attitude of the midwife in the environment is also significant. This is reflected in Denis Walsh’s work on birth centres (2006, 2007a). This was further agreed by Archie.

\[\text{Archie(H):} \quad \text{I do [think it’s the environment ] but I think it’s the midwives, the [birth suite] midwives round there are so dedicated…You do hear the midwives on labour ward saying I can’t go crawling around on my hands and knees round there so that’s already such a barrier isn’t it?[laughs]. So there is attitude here, definitely.}\]

For these midwives their choice of where they worked may have been related to personality of the midwife, as highlighted previously. However the choice may also be in relation to where a midwife feels her skills are best used. For example Kerry has chosen an area where she perceives women have more need and she can be a ‘proper’ midwife.

\[^5\] An aromatherapy oil used during pregnancy and labour to aid relaxation.
Kerry (C): But I think...that different midwives suit different jobs in different areas and different needs. For me when I worked in that area yes I probably was good at doing all of that but I didn’t feel I was doing proper midwifery because I was telling people probably what they already knew and what they wanted to hear and I was probably just a gatekeeper for them getting what they wanted.

Whereas, for Jennifer, who likes the idea of being a midwife in a small birth centre she also likes being able to use more technical skills in the hospital setting.

J-A(H): [sighs] yeah you wouldn’t have these sort of problems would you if it was a birth centre because you wouldn’t have the doctors involved and you wouldn’t have the hierarchy and you wouldn’t have the intervention probably-so yes if we all worked in nice little birth centres- but then you see on the other hand that’s a double edged sword- I like being able to cannulate, I like being able to suture, I like being able to scrub for caesarean sections and I do see that as an extension of my role so maybe that’s how I’ve changed. But even when I was a team midwife I always wanted to be able to do those things anyway and I always maintained those skills.

Lucy indicates that for those working in a busy hospital unit there is a potential that the high technological way of working can become acceptable and ‘normal’ to them, as that is all that they see on a day-to-day basis.

Lucy (C)...if you work within a major... hospital centre where you are seeing predisposing medical conditions and high caesarean section rate that perhaps ...does start to become normal for...the service that you are offering, the care that you are giving. Quite possibly if you are there for any length of time maybe practice becomes ‘normal’. Again possibly depends on the individual... But I would imagine that there are a few that enjoy theatres because it is very task orientated....

The implications of this would be that it is beneficial for midwives to rotate into different areas of practice in order to remain skilled in all aspects of care. However there are disadvantages in this as well as there are major benefits in having
midwives in each area who personally want to be there. The practices in each area change so rapidly with new equipment, drugs and guidelines that it can be a challenge to constantly move and may have an effect on safety. The view of Lucy about the high technological environment is in stark contrast to the significance the midwives attribute to the home environment of care.

S-A(C) …to me that’s the one aspect of my job that I love more than anything is to actually go into a lady’s home and to deliver that baby into the home situation, where everybody’s in their own surroundings, they’re their natural selves, and to not necessarily feel as if you are a guest in their home but that you are a trusted member of the team within the home situation…I am not saying you don’t get that in the hospital situation but in the home it almost seems more powerful.

Kerry (C) That’s the cherry on the top is the home birth, I think that is just the crème de la crème and especially if you have seen somebody antenatally, delivered them and postnatally that is great job satisfaction, that is just what your job is all about.

Lucy (C): I think it’s different in the community… because…I have been on the community for a long time…it’s almost like visiting friends again…

The midwives indicate the community is more conducive to practising midwifery, ‘art’.

Mary D (H): I worked on a [community] Team for 18 months and… I was in that mentality that I was actually practising the art of midwifery more than I do at the moment.

Archie (H): I think probably the biggest demonstration for the art of midwifery would be a home birth that I was at…at home the woman creates her own environment...and you very rarely have noise in the home and bright lights and is usually created a corner which is dark, more homely, a nest; it’s the natural thing to do.

If the home environment is so important it could be questioned why these midwives
felt as comfortable in a high technological environment as they viewed their time in community teams as significant to being a midwife: There appears to be a level of compromise.

J-A (H): Little has changed my practice but doing team midwifery had a profound effect enabling me or facilitating me to truly love women and their families.

Archie (H): …I thoroughly enjoyed the contact with the women in all aspects of their care, and to really know them and their families throughout the whole of their childbearing experience was very enjoyable, and a far cry from the conveyor belt routine of hospital care… The home births were a humbling experience, and renewed my faith in normal midwifery.

They also suggest that the area of working affects how they practice which Archie suggests maybe related to personality.

Archie (H): I think there is a huge difference between team and hospital but that's why I also think that if you are the kind of person or the kind of midwife that can put people at their ease you can make the hospital environment homely and get to know that person quite well as well. But obviously the team situation is a lot more intimate because you know their family as well and you see their background and you know their other children and so you become more of a friend. I think we need to try to do that with everybody. Just think it's a very quick process sometimes [laughs] in the hospital…Different people choose to work in different environments because of their personality, definitely.

Sally-Ann suggests the midwives’ differing personalities could lead to conflicting advice.

S-A(C) I think it’s the different midwives; again they use their own experiences to try…and advise and that may be a completely different experience to what another midwife has had. I don’t think we mean to conflict, I think it’s just different personalities and different ways of
Jennifer also states that her practice is affected by where she works.

J-A (H): *But it isn’t very often like that in practice, that beauty and that magical time is taken away. But I think that at a homebirth you do get that... because I practice differently as a co-ordinator on delivery suite than I ever did as a community...*

Sally-Ann also identifies that the community and hospitals have differences, and suggests that this changes how she practises, mostly because of the relationship that can be built up.

S-A(C): *There is definitely a difference in the way I practice in the unit than outside in the community although again that depends on how well you have got to know the woman and her family really. But you are definitely far more relaxed, you are much more able to build up a rapport with somebody...the community.*

She qualifies this by suggesting dress code and clinical equipment make a difference to her.

S-A(C) *I think just the art of putting a uniform on changes your persona. You don’t become something different but just putting that on [takes on a different role] yeah, It’s almost that you are acting a different role I suppose, whereas, at home we are generally in your own clothes; I quite often ask if I can take my shoes off and... it’s much more comfortable, much easier to build a rapport with the family. You have got none of those...surgical instruments, none of those things you associate with hospital around so it almost feels a much more natural process. You haven’t got anything sort of on the side lines that could interfere with the process.*

I reflect on how uniform and dress code are like masks behind which we can hide. The debate about midwives and uniforms has been around many years (Cronk and Flint 1989:21) and remains (Baxter and Pride 2008). There are health and safety
reasons for midwives to be in uniforms as well as for members of the public to recognise professionals. But should putting a uniform on make you a different midwife? It is still associated with ‘being a nurse’, ‘being in authority’ as well as for the midwife to hide herself behind the uniform.

Connie considers being a midwife is not changed by the physical environment but by the individual person she is caring for.

Connie (H): … when I enter any room…I would be the same but I think what you do is change your practice depending on what you are meeting when you go in, what your case is, and I think that’s experience. I would treat everybody until proven otherwise as ‘normal’ and it doesn’t matter whether I am in the high risk unit or the birth suite my approach would be the same.

However she recognises there are differences in the way she works in the birth suite.

Connie (H): I am kind of labelled as a high dependency coordinator and I went to work on the birth suite a few months ago to help out. I was with a very junior, newly qualified midwife who is pro-birth suite, everything’s low risk and she was shocked at my practice because she had perceived all I could do is look after high risk women. But I, like her, can be on the floor and be quiet and do all those things and give good care.

Mary D also felt that she practises the same, whatever the environment and that it is women’s views and choices that make a difference to care in the community.

Mary D(H): I don’t think I … practise any differently [in each area] just the client base that we had, had different concepts and different ideas of what they wanted their labour to be… I go along with what any woman wants. If she says to me she wants an epidural at 3 cm that’s fine and I will support her whatever. But if somebody said they want to swing from the lights and do bouncy balls and all the rest of it, that’s fine and I would embrace that too, so it is client led…however much you can educate women it’s got to come from them. I do find that quite hard.
This reflects the current debates about women having choice including the complexity of whether that means giving them everything they want, even caesarean sections (Weaver et al 2007, Paterson-Brown 1998). It is clear from Mary’s comments that the professional relationship midwives have in this situation is complicated and may be related to personal bias. I acknowledged previously my potential bias toward normal birth and some midwives choose to work in the community where they will not have to face the complications of choice raised by Mary. However Connie values her work in a high technological delivery suite.

Connie (H): I’m at a lot of low risks births; just by being second midwife and just by being the support to the junior midwife. I am very much part of all of that but I am also very much part of the high risk area and for me it doesn’t really matter … I think I’m lucky in that I get both… I don’t think I valued the low risk deliveries when I was in the community as much as I do now…In the community it becomes very routine. Whereas when you see things that go completely the wrong way at times and you end up in an emergency situation you can see the differences but at the end of the day the outcome is the baby and it’s the family and it’s how you as the midwife makes those people feel about how they got their baby. It’s about not making them feel they failed.

Her view comes out of a concern that women are being made to feel that they have ‘failed’ if they don’t get a ‘perfect birth’.

Jennifer believes that what women want out of a midwife is different to how a managing coordinator on a busy hospital unit is expected to behave.

J-A (H): I like people to think that I’m nice, lovely kind to people. That’s when I walk out of the room I want people to think, she’s a nice midwife, like you do, don’t you? But I wouldn’t particularly want that if I was running delivery suite; sometimes you have to make unpopular decisions. So I want people to think ‘oh I feel a bit safer if she’s here, she knows what she’s doing and it’s run well and she’s fair’ but you don’t want that when you are in a room with a woman…
There are obviously challenges here where midwives are not expecting to take on this type of role when entering the profession.

For Jennifer there are differences in her experience of autonomy related to the coordinator role on delivery suite.

J-A (H) …you are expected to be this very…autonomous woman who knows everything about delivery suite, can support junior doctors, can direct registrars to making the right decision, have to liaise with consultants that maybe will refuse to come into the delivery suite and to suggest maybe it's important that they do. It's a very high impact managerial role. You liaise with the supervisor of midwives, it's your responsibility if the delivery suite becomes too busy and if there is an incident that happens and you haven't alerted a certain number of staff or you have decided to close the unit then you are blamed- why did you do this, why did you do that, why did you do the other?

This role is rarely presented as the public face of being a midwife and is obviously intensive, carrying considerable responsibility. It has evolved over time with the increase in high technological centralised units, which sometimes include high dependency beds (Saravanakumar et al 2008). However Sally-Ann presents a different view of autonomy in the community environment.

S-A (C) I think at home things are a lot more relaxed. You are not so concerned …In hospital I think you always feel you need to be standing to attention… You have always got somebody looking over your shoulder…you are almost always answerable to somebody else, whereas in the home situation it's you and generally only you until you actually come up to delivery when you have a colleague; but that colleague comes in to assist you rather than to come in and tell you what to do if that makes sense…

She feels that the hospital coordinator acts as a ‘manager’ to other midwives. Archie indicates that the labour ward coordinator has a responsibility in affecting the art of midwifery where she works.
Archie (H): Over the 2 years that I had been out on the Team, it seemed that defensive practice had evolved, and midwives were now practising more carefully than ever before. This seemed quite opposite to the Birth suite philosophy that had arrived in the same unit; two very different worlds divided only by a set of double doors. The doctors are not allowed through the birth suite doors… But the division is there definitely because there’s no interference from the coordinator of what is going on, we don’t even want to know what dilatation they are or anything and that’s lovely because they are kind of cocooned and so they can do what they like down there…

This is interesting as the coordinator is always a midwife. The birth suite midwives are always ‘left alone’ which indicates the coordinator does not interfere and influence what is taking place, yet they do interfere in the main unit and the same midwives accept this as being the case. The concept of the division of two worlds simply by a set of doors is also one that is a powerful indication of how environment is influential on whether midwives are practising the ‘art’ or not.

In their discussions both Sally-Ann, in the community and Pamela, working in a hospital setting, use the same phrase ‘the buck stops with you’ to show that they feel responsible and accountable as midwives in these settings.

S-A(C): … I suppose …at home: the buck stops with you, whereas in the hospital if you’ve got concerns you have got other people there…not that they are not available at the home, coz they are only on the other end of the telephone line but…I think at home it makes you more aware of just how accountable you are and just how much responsibility you have got as midwife…You’re far more aware of your responsibilities and…how complicated the whole process is really and just what can interfere with it and what…could go wrong…and that whole responsibility’s on your shoulders…

Pamela (H): I don’t think it’s because I am in charge of delivery suite. No, it’s my practice as well, with me the buck stops with me. Yes, you are advising someone- but their practice is their practice and if they do something you wouldn’t do in your practice, they have to hang
themselves for that really...when in an emergency situation and there are so many people...and you just have to act swiftly and hopefully you are acting in the best responsible manner and...where everybody has to work together and you are conscious I am the lead in this shift and everyone is implicated. So there is a teamwork aspect to it as well and some of the registrars are definitely not as experienced as they used to be and they definitely haven't got the skills.

An awareness of personal responsibility in both environments is obviously a key meaning for these midwives. Sally-Ann’s perception of an individual midwife’s responsibility in the community is echoed by Pamela’s assertion that, despite the number of people around on a delivery suite, the midwife is still accountable for her actions (NMC 2004).

**Physical aspects of caring**

The role of a midwife involves physical actions of caring and these midwives related some of these aspects. Archie is clear that the art of midwifery is not just in relation to birth, and includes knowledge of anatomy and physiology and the application to the care.

Archie(H): … … I do think there’s a huge amount of the art of midwifery in helping the woman to deliver her own baby in the best way that she can and also if the baby is slightly OT or OP\(^6\) and also by the woman is pushing as well you can kind of get a feel by checking inside where the position of the head and where the baby’s head is to the spine and the room within the pelvis, that kind of thing. You are assessing all that and...if you are stuck in a home situation without help then…you really have to be on the ball and think what else the woman could do or you could do to help her birth a child and that's a massive part of the art of midwifery. [So it's understanding anatomy] yes and physiology and the whole picture of what is going on...And also expressing milk as well and helping women with breastfeeding, there is a massive art to that and helping woman with postnatal things as well...bonding and breastfeeding is massive, it's a hugely womanly art and that is really

\(^6\) Occipitotransverse, or occipitoposterior: position of the baby in the uterus indicating which way the back of the baby’s head is pointing in relation to the woman’s body.
something a midwife can help with because it’s a lost art as well I feel, the mothering side, the bonding, …and the art of midwifery is also… helping the woman to see it was a normal process and even her sexual side is lost often because they are in pain, their bottom feels like it’s been blown apart and there is that massive changeover to motherhood is so huge and that is also a huge art of midwifery to bring the mother into a new role which is massive culture change isn’t it, that’s a shock to the system.

I am struck by Archie’s referral to a ‘womanly art’ and the indication of the physicality of the issues she is discussing: from vaginal examination at the start, to mentioning breastfeeding and sexuality. The art of midwifery is thus grounded in intimacy with women’s bodies.

Mary D relates some of the physical aspects of caring in relation to the art of midwifery.

Mary D(H): Just caring about people, caring that they have a good experience, caring how they feel…and you can do the physical caring…, for somebody, what we used to call basic nursing care, keep them clean, do them up, make them comfortable, meeting their needs, emotional and physical needs but also caring as a person you want to do a good job as well.

She is clear here that meeting a woman’s need for hygiene and comfort is important as an aspect of caring. Jennifer considers beds as significant in the physical environment.

J-A(H) yes, move the bed and make another focus in the room, but I think it’s important in active birth that the woman does get on the bed and have a rest because you can’t be on your feet for 12 hours. So yes periods of activity followed by periods of rest and she lies on her left side, and soothing music and her husband’s…or brushing her hair… or whatever. How can you be comfortable lying on the floor?

In contrast Archie thinks that the ‘true’ art of midwifery lies in situations where there
is no equipment.

Archie (H): I would like to travel…and go to other parts where I think you would learn an awful lot more…I think by saying how poorly off other areas are we realise how well off we are…and I think with no trolleys, beautifully made up packs and an operating theatre around the corner you would seriously experience the true art wouldn’t you?

Jennifer also agrees that the presence of equipment has an impact on the art of midwifery.

J-A(H) I think the environment does matter- if you haven’t got a CTG⁷ there you can’t use it, If you have got a CTG there you use it. At home deliveries…it’s different because your phone is taken away, your colleagues are taken away, you’re not running into another room, you don’t have an emergency, so it’s bound to be calmer isn’t it?... I think, me included, you do put women on beds and slap them on CTG’s, because…you do a baseline CTG and if that’s alright we’ll make a plan from there…It took me ages to move off that…purely because I worry for how long people will listen in for. Do they listen in for the full three minutes, do they listen in through a contraction?... I’d worry about my own practice as well especially if you are busy, you can’t just sit there, and three minutes is a heck of a long time when you are rushing around; which is an awful thing to say- so I was definitely a baseline CTG girl, and if the first CTG was fine I would intermittently auscultate, that wasn’t a problem.

Mary D suggests that some midwives now need equipment to make them feel secure.

Mary D (H): …some midwives feel possibly insecure; sometimes they can’t be bothered, sometimes it’s easier now for women to have an epidural than it is to care for somebody emotionally. You know…midwives now don’t even take a blood pressure every 5 minutes, they put a machine on to do it. I remember when I trained when people

---

⁷ Cardiotocograph: an electronic machine used to graphically represent the baby’s heart rate and the woman’s contractions in labour.
were sluged with [drug name] which made them numb from the waist down and couldn't move: it was a physical effort for the midwife as well as the mother to have an epidural... you knew it was going to be a long second stage...you made syntocinon, you have got to do 5 minute blood pressures every time they have a top up, all those things made it hard work- but now, women have Readymix\(^8\), they can push adequately when they have an epidural, they can move about the bed, quite well without the midwife having to help them, we've got [machines] that take blood pressures automatically without you having to get off your back side and do it, so it becomes that much easier, it's not so much hassle, for some midwives to suggest an epidural. Its far more hassle for them to be with that woman constantly and support her and breathe with her and do the eye contact and that emotional thing…

Lizzie also relates the issues of equipment and the problems this can sometimes create for midwives.

Lizzie (H): It’s not everybody’s choice to go in a birth pool but… it’s not very conducive for midwives for the manual handling practicalities. It is actually quite unsafe to midwives to practise especially with the height of the bars we have and not all midwives have the stature to...help the women as best they can. We have had quite a lot of back injuries and knee injuries and also there is a health risk to it especially with all the debris that floats in the water although I don’t dislike water births I think you have to be aware of that.

The implication here is that equipment may be of value in certain situations; however the midwives are concerned it is being used indiscriminately by some and may be affecting the ability to provide the art of midwifery. In addition the use of some tools to provide the art of midwifery, the birth pool for example, may be causing problems to some of the midwives caring for the women.

*Time*

A further aspect in relation to the physical aspects of midwifery that was

---

\(^8\) An epidural drug that is already prepared.
discussed relates to the concept of time. For Pamela the art of midwifery lies in giving time to women to give birth, to allow nature to progress.

Pamela (H)… just the experience and the belief that if you can say to women I am here with you, I’ve got time to be with you, we can do it. It has changed my approach in practice in that I’m a bit more laid back about it really, and especially when you are in charge and you hand over to the medical people I can stand up and say let’s leave her, she’s fine… and see what happens and you know at the end of the day, it didn’t work, …the meaning of midwifery can be very basic. I suppose I mean it’s just the fundamentals, developing a relationship and time, everything’s’ time isn’t it- that you have time with the woman, and that you can see her labour progress..

Pamela is suggesting here that she has confidence to know when to let women take their time in labour on a hospital birth suite. Lizzie feels that there is more time in community to provide the art of midwifery.

Lizzie (H): It’s about building up relationship and also if you have a home birth you have a lot more time where usually…we had time to meet everybody… I mean in the hospital if you think someone comes in labour 4 or 5 hours later they have delivered that’s the only time you will see them, you know to build up that rapport before they deliver, whereas with the home deliveries form my experience you have had several weeks if not months to build up that rapport.

For both Jennifer and Kerry there are frustrations with lack of time in both the hospital and the community.

Jennifer-A(H) I do think about the environment a bit more and some days if I’ve got time I will do all those things but some days when I am running into two rooms it’s impossible to do it really; and it’s just time. Yes-I would love to be siphoned off into a room with somebody

Kerry (C): But you are trying to do all this and then the ball’s flying out of the air because you’ve only got a 15 minute antenatal appointment so they’re spiralling. You’ve got somebody coming in that’s very upset and
you almost want an alarm clock; sorry times up now-how could you ever

do that in our job? And clinics run late so that runs the rest of your day

late; there’s you not getting a lunch break and then you are getting home

late to your family where you are trying to juggle your family balls in the

air.

For these midwives the art of midwifery is identified as needing time to ensure

women get the best care, but recognising this is outside of their control. In addition

personal time is eroded in all the ‘juggling’ that is required.

8:4:4 Psychological and emotional aspects of midwifery

In their discussions the midwives in this study clearly identified emotional

aspects of their role.

Positive emotions in midwifery

These midwives who have been in practice for many years indicated their

enjoyment and pride in the role.

Lizzie (H): I like both hospital and community. I have to say I like all

aspects. I do like the antenatal aspect, I like seeing people right at

booking. I like seeing them go through. I enjoy doing parent craft you

know going with them and knowing the women and then delivering them

or being involved in their delivery and I like seeing them postnatally. I like

the whole aspect of being midwife.

Pamela (H): …it is pretty amazing stuff: when you think about what you

do as your job… I am proud to be a midwife

Mary D talks of the emotional aspects of being part of a birth.

Mary D (H): I still find yes delivering a baby really special and I think you

get more emotionally involved in some than others. Sometimes when

you are actually concentrating on the delivery, you are not detached

from it but it’s not as emotional. Sometimes I find, certainly when I watch
births on the telly, that I find it more emotional…so if I go into a room and I’m just there as a supporter or whatever you can look at the whole thing and the wonder of it…I think it’s why I am still there 25 years later I suppose.

It is evident here that the midwives feel deeply passionate about the role and how it makes them feel in return. For Lucy she finds satisfaction in resolving challenging situations.

Lucy (C): Every once in while you get an unusual case that makes you feel good about yourself, and gives you that great satisfaction and empowerment…

These issues return to the concept of midwifery as being part of their identity. Positive emotional responses are therefore tied up in who they are and the pleasure they gain from the role.

**Negative emotions in midwifery**

In contrast the midwives also mention more negative emotions associated with being a midwife. For some the role generates a level of fear. For example, Pamela developed intense fear in relation to labour at home leading to her working in the hospital setting.

Pamela (H): Home births just don’t do it for me… I can do it and I can be confident doing it, but always in the back of my mind, always in any aspect of my practice, always is the fear that something could go wrong and that is what is deep in your soul.

Kerry also relates the fear of being a community midwife in challenging situations.

Kerry(C): [being scary] happens in every part of your job I suppose from antenatal to somebody being abusive to you that you know has got child protection issues and don’t want you in the house and being very, very aggressive towards you and swearing at you to following them down the line to child protection and going to court and making sure you’re doing
everything right protecting that child to the total other flip of the coin to being at home birth with a multip⁹ that’s been pushing for an hour, an hour and a half and you’re starting to get the wobbles inside in something about your intuition is telling you, right you’ve got to do something about this. And it might not be transfer in; it might be…getting her up and down the stairs- I had a home birth last week…got her up and down the stairs, really supported her, doing squatting and standing and the baby was delivered beautifully. But something after an hour is telling you that’s not quite right, and the baby came out a 4.4kilo baby, which you know, you can’t see…but something’s telling you it’s not quite right so that is quite scary. But you never, ever show that, you’re looking at your second midwife, never ever saying anything but looking at her; you are seeking with your eyes. Quite unique I think in our job.

In the community then there is an indication of the midwife being aware of powerful moments of anxiety or fear that ‘something is not quite right’ and needing to be in a heightened state of awareness. Pamela views this as being a positive emotion, in order to be able to do her job well.

Pamela (H): I think it’s good to have that fear within yourself…I have seen it with other people with no fear, and are just really blasé. I think it’s what you need to be good. I think it’s a fear you have to have to do your job well within your self- I can look confident, I can do it and I am happy, exteriorly I am fine, but always in the back of my mind or in myself I am conscious that it can go wrong.

This fear that ‘something can go wrong’ can also lead to midwives practising ‘defensively’, a ‘just-in-case’ mentality. Archie relates how fear can result in ‘defensive' documentation.

Archie (H): Well it worries me… that we will end with a system of Obstetric nurses, it frightens me hugely. Because of litigation it’s killing the midwifery role…I teach neonatal resuscitation and there was a independent midwife this time and … we have to mention documentation at every station… It was really interesting to listen to her, hear our fear

---

⁹ Short for multiparous: a woman who has had more than one birth
about documentation. Because she can practise freely and she isn't so het up with documenting this that and the other and I think that we all felt what she was saying was really, that's what impinges on our art, that we our writing more than we are doing, and that's all a litigation scare isn't it? I found that hugely distressing from the art of midwifery point of view…It's coming from clinical governance, from CNST\textsuperscript{10}.

In addition to fears about things not being straightforward a number of the participants related stories of distressing situations they had experienced as midwives, mostly in relation to working in the hospital. It is viewed as being something to accept as part of being a midwife. Both Pamela and Jennifer A indicate the emotional pain they feel when dealing with difficult situations.

Pamela (H): I just want to say the most connected I have felt with a woman recently was she had an IUD\textsuperscript{11} at 38 weeks, and I delivered her baby and it was just really moving and I felt now isn't this really sad…and I came away thinking that I invaded her life because I had delivered her baby and she will never forget that it was me. It's because you want to give them something because they've got nothing…they haven't got a baby…I find it so devastating, completely devastating when anything like that [happens]….I cry a lot and think about it when I get home and they put up with a lot really.

J-A(H): The horrible days are when something didn't go right or you know a baby's not well, and that really affects you…It's what I don't like about the job: I can't move on from that. I'll spend two or three days going over and over and over and…this reflection that you get is obsessive. And very often it's nothing that you've done…but the good days are brilliant and the bad days are awful, and that's midwifery I think.

Midwives therefore have to mediate the more distressing situations in order to cope with the role. There is a need for maintaining perspective in these tragic situations. Mary D recognises the need to ‘feel another’s pain’ but also to retain a sense of self control and caring:

\textsuperscript{10} Clinical negligence scheme for trusts: insurance scheme for the NHS
\textsuperscript{11} Intrauterine death: the death of a baby in the uterus before birth after the 24\textsuperscript{th} week of pregnancy
Mary D(H): …we had somebody the other day who looked after a termination or it might have been an IUD\(^{12}\), quite early on pregnancy, and they were very upset and they said ‘oh I cried’ and I said ‘that’s fine’ I said ‘I’m a mother…you know I’ve cried’. But there’s that fine line of showing you care but also you’ve got to do your job, and you’ve got to wipe your eyes and go out the room and do what you have to…You can’t be a weeping, railing wreck then, you wouldn’t be supportive and caring to the parents. But you can show that you care and I think the moment you stop showing you care then that’s a dangerous path to go down because then you don’t possibly give that emotional support. I think that’s the nurse in you as well, you’ve got that nursing instinct to care. I think … that comes from because I was a nurse first; more so than if you want to be a midwife. I think some midwives want to deliver babies, I think sometimes it is a shock to some of the Direct entry midwives…they go into it with the experience of their own childbirth or relatives’ childbirth…and they’ve a little bit of a rose-coloured tinted idea of how lovely it is to be a midwife and sometimes I think the reality is difficult to deal with.

Here Mary suggests that her acceptance of death is related to her nursing experience. This is of relevance when we now consider the majority of students are now not requiring a nurse qualification first. In addition to situations of grief Connie relates how midwives also have to face violence in the work place.

Connie: Recently… [I cared for] a…young teenager, a teenage boyfriend… and he was becoming so childlike because he was a child …and I did ask him to leave. And I felt awful, but I felt I had to take some control because she was becoming hysterical because he was frightening her but that’s the first time ever… I have been in… awkward violent situations. Even in those situations you do your utmost to keep people in a room because you know when you have stepped that line and make them go it’s very hard to come back to a relationship that you can build on again once you’ve been that final. So I did feel very uncomfortable about asking him to go but he was just escalating the

\(^{12}\) Intrauterine death: the death of a baby after the 24\(^{th}\) week of pregnancy
Both Mary D and Connie express concern here of negative emotions and a competitive nature that comes from other midwives on duty in their unit and how these then affect the women.

Mary D (H): …it must be something within us, we all want to feel… we don’t get enough praise… its funny the more senior you get the less praise you get…and we all want approval. So possibly it’s that insecurity when you come on duty and the previous coordinator tells you ‘it may look like good now but we’ve been so busy and we’ve done so many deliveries da da’ and wants to relate to you all what has gone on and in fact all I want to say is actually that’s fine can we just do what’s here? Possibly I don’t need to hear about everybody else but they feel they need to offload that all the time.

Connie: I hate to hear this embittered tiredness and how awful things are because actually things aren’t that awful; awful’s third world countries where women are walking for 5 hours to get anywhere; awful’s where women are having stillborn babies and are dying from preeclampsia and haemorrhage. This isn’t awful; this is pulling the emergency bell and the cavalry comes… I know this is tiring but no one makes you do it. I just think there is a culture that has crept in of moaning about how tired they are and how hard the work is …

The indication here is that midwives coping strategies are individually different and some may cope better than others. Midwives obviously work in challenging environments where they have to deal with both happy and painful emotional situations. The next section relates to comments about need for greater support in order to cope.

**Need for emotional support**

The hospital-based midwives here talked about support as being important to them in their practice, addressing this as being something they recognised is missing. Jennifer A suggests that midwives are not helped enough with the difficult
situations they have to deal with.

J-A (H) It’s interesting…isn’t it, we recognise we do a really stressful job and we have sometimes very difficult situations to cope with and there’s a wonderful birth afterthought service for the women but nothing for the midwives.

Jennifer raised the contrast between her current work on a busy delivery suite and being part of a team community practice:

J-A (H): I can’t switch off from it easily- but on the team I didn’t feel it so much. I think that’s due to the support network, because on the team you are a very, very small group of girls mostly in the same situation and you have an enormous amount of love for each other so there’s never a crisis because everybody will sort it out. So if somebody’s says ‘oh my granny’s ill’, ‘I’ll do your shift’ and there was lots of fluidity with the shifts and covering and supporting and if somebody was ill you’d be ringing up ‘are you alright?’-You’re anonymous on delivery suite. You are quite isolated…if you were off sick for 2 weeks probably people wouldn’t realise, quite uncaring really… and I’ve seen what can happen to some of the midwives which feels sad when they’re not supported or they’re criticised or they’re talked about behind their back, that’s what I find hard.

She describes here how a smaller team is likely to be more supportive to each other. Pamela agrees hospital delivery suite is more impersonal.

Pamela (H): You don’t see people on the delivery suite, the shifts we do, the different patterns of shifts…

Pamela believes her main role is to be a support to other people she is on duty with.

Pamela (H): It is big for me to be supportive and it’s big for me to make the shift a better place, whether it’s my personality or whether I’m cheerful or whatever. As long as I make a difference to the people I work with, possibly secondary to the women I look after, that’s why I go to
work. I think that the meaning of midwife is to do with making a difference to the day that is evolving.

Pamela is talking here about ‘midwifing the midwife’, a need for women to be providing a support network to help others (Taylor 1996). As an experienced midwife Connie views that part of her ‘art’ is in relation to educating more junior staff.

Connie (H): Part of the art is supporting other midwives because I want them to feel like I do.

She explores later that, as a coordinator, she can recognise when another midwife needs a break from a difficult situation.

Connie (H): I think as a coordinator you are in and out of lots of rooms. But just those little things you do when you are in the room and it’s not necessarily for the women or the partners sometimes it’s for the midwife. Sometimes it’s just recognising on their face that they actually need two minutes out of the room, saying why don’t you just pop out and I’ll stay. Because you read a situation where you can see those people aren’t the easiest people to spend 5 hours with, they’re not the sort of people that the midwife’s gelled with well but she’s trying her very best. It’s just sometimes recognising that when you walk in.

Jennifer suggests that this also works two ways with managers not feeling supported by the midwives.

J-A (H) I definitely know the [removed] manager doesn’t feel supported by some of the senior midwives, definitely she feels like that. She feels she doesn’t have their support, she feels she doesn’t have their respect….

In contrast Mary D is concerned that the greater levels of support available, compared to when she first qualified, are causing more difficulties.

Mary D (H): Birth rates going up, midwives not increased accordingly in numbers and we have been under stress…and…I think a lot of the young ones need a lot more support… and get it more than we did I
think and sometimes they need that support for longer: possibly not of a generation that move on and accept things that happened... sometimes I think they are a little bit unrealistic in their expectations... we have another midwife who... for some personal reasons, can't look after some aspect and you think,... -we have all had personal issues and we go to work and you should work as a midwife...If you are doing a job it's very responsible, and you should be mature enough to actually accept things that happen sometimes and actually put it into perspective. You know I would be the first to support anybody if they had actually done something wrong in their practice... and of course, you can understand all their angst about things if something has gone terribly wrong and they've been at fault... but when there's absolutely no fault of theirs and you can say that, and they know that, but they cannot move on and still hang on to that and it just colours their practice for many months and I think that's a real shame and I don't know what you can do about it, it's just their personality.

She continues by relating experiences of her past, where support for midwives was limited, and she describes the need to ‘get back in the saddle’ as there was no other option. It appears from these comments that there is a need for balance between giving support when needed and ensuring midwives are in a suitable emotional place in order to be effective in the role.

A final comment related to support comes from Kerry where she reveals that the midwife’s role is not currently all that she anticipates it to be; that many midwives are not now practising as they signed up for.

Kerry(C): ...On speaking to lots of midwives they would probably want to be a Doula\textsuperscript{13} rather than a midwife;... instead of doing all the writing and what's expected as a midwife, rather than being with a woman in labour and supporting her. That's why we have independent midwives really, that they can offer that whole service, antenatal, labour and postnatally. The idea of being a Doula sounds fantastic.

The implications of this lie in the need to revisit support for midwives and examine

\textsuperscript{13} Doulas are employed by women to provide support during labour and after. Their numbers have increased in recent years in relation to the reduction of one-to-one care in labour by midwives
why midwives are not supportive of each other when they are clearly meant to be supportive of women. In addition the amount of paper work appears to be leading to a loss in the midwife’s supportive role.

Meeting emotional needs of women

As explored in the previous section these midwives indicate that ‘being a midwife’ and having a baby is an emotional event. Midwives are expected to give psychological care to ensure women are supported. In this section the midwives discuss the emotional aspects of care. Kerry states that the art of midwifery care lies in appropriate communication.

Kerry(C): I think this is art, communicating with women, being with women, understanding them, recognising their fear and allaying those fears.

Fear in pregnancy has been recognised as significant for many women (Otley 2011, Nilsson and Lundgren 2007). Therefore enabling women to reveal those fears and aim to reduce them is an important role of a midwife.

Sally-Ann also indicates the importance of building up relationship and meeting their emotional needs.

S-A(C) It’s trying to tap into to how they’ve become, who they are and providing the best support for that…I think it would be nice to be able to tap in and actually hear what a woman’s thinking because…there’s things that they want to say but not necessarily feel that they can say them or how to say them and I think it’s trying to build up that relationship with a woman so that they’re comfortable enough to be able to tell you even their innermost thoughts and how they’re feeling.

For Lucy she believes her role is to encourage a woman to have more confidence in herself.

Lucy (C): I think women need to be encouraged in their own self-belief and still very often we hear women that…even before they conceive say
that they want a caesarean and they want an epidural and I suppose what as community midwives we are trying to do is… to … encourage them to think outside of the box that actually maybe they don't need and they don't want and they should be more open minded and a bit more positive and…try to…listen to their bodies and do what their bodies want them to do rather than just saying yes of course you can have an epidural…By just trying to make them think that there are alternatives, and to think further afield and to have a knowledge base that empowers them into being as normal as they possibly can.

Emotional support by community midwives is therefore seen as an essential aspect of the art of midwifery in preparing for labour and birth. Archie also recognises in the hospital unit that part of the art of midwifery is using communication skills to judge how to respond to women and needing to adapt care accordingly.

Archie (H): I think …it…depends on the personality you are dealing with. If you have got a woman who is being abused who doesn't want to be touched you would have to severely change your practice to someone who …needs mothering and wants as much touch…as they can possibly get. It’s body language and it’s building up a relationship really because when a woman first walks through the door you’ve no idea, unless you do know them before hand, what kind of person they are, so they might have had a non-touchy feely upbringing and they might not see things the way you do. It can take a little while to break down those barriers …so I think first of all its important to get to know the person and then from there the knowing comes from all of it…a little bit of their background, which if you can talk to them openly they do tend to open up a little bit and then body language, because sometimes people will retract if you try to touch…and some people will call for you if you are not there by them or with them enough…. It’s the initial staging of things that’s the skill. I think I meant that by the skill, obviously there are household things as well but the art I see as more of a psychological thing.

In addition Archie views the postnatal period as a time where emotional care is important.
Archie (H): It’s not just about labour because the postnatal period is also a very difficult time and a huge time of adjustment and a massive culture shock. And I think that you can be someone’s leaning block and mooter them through it really. It’s more the psychological perspective thing the art more than the practicalities of it.

In current services postnatal care is becoming more fragmented as there are cost cutting measures taking place (Carne 2011). Women therefore maybe losing out on valuable emotional support.

8:4:5 Spiritual aspects of being a midwife

The issues of spirituality have been discussed previously, and recognised as personal to the individual.

The midwifery role as spiritual

Some of the midwives mentioned the word spiritual during discussion. I asked them what they meant by this. Kerry does not equate this with religion.

Kerry (C): I am not a religious person at all and I don’t’ foresee spiritual as… particularly being religious. I see it as understanding yourself and almost like a meditation of knowing yourself within and that’s how I perceive spirituality and again with being deep it’s really looking within yourself and bringing that out.

Pamela also agrees that it is not about religion and suggests that our society in the UK is not particularly spiritually aware.

Pamela (H): It is hard to define spirituality. I don’t think as a society we comment on it because I don’t think…we are very spiritually minded. Its kind of just not something you talk about…. But I think when you ask people what is spirituality I think they feel they must come up to say that well I don’t {believe} in religion, it’s so related to religion and actually it probably isn’t…
It is a common view to suggest spirituality and religion are connected though it is considered to be only one way to express spiritual beliefs (McSherry 2006, Swinton 2001). Jennifer explains that spirituality is not about religion for her and she finds it difficult to verbalise what it means.

J-A (H): I regard talking to my kids as spiritual, as is keeping regularly in contact with family and friends who I truly love and meetings regularly with girl friends for lunch gossip and giggle … But what is spiritual?…Isn’t it just being with the woman? Isn’t it [about religions]? But it’s a bit like getting intuition isn’t it? How can you…verbalize it?

Her suggestion here is, just because you can’t see it, it doesn’t mean that spirituality does not exist, which makes it all the more difficult to research and to provide spiritual care (NMC 2009). Sally-Ann views spirituality to be an integral part of being a midwife.

S-A(C) By spiritual I mean…what makes the woman what she is and who she is, what drives her, and as a midwife what makes me the midwife that I am and how I can actually use my feelings and spirituality to bring out the best in the woman and to build a relationship with that woman, so it is quite a lot to do with relationship…

Pamela also believes that there is a link between being a midwife and spirituality.

Pamela (H): I think there’s something… it’s intrinsically linked that I think it’s not just a job. I don’t know…would you feel the same if you were a nurse?…no you wouldn’t actually, because you could go and leave at 3.30, but if you think this woman’s pushing and this baby’s coming you don’t leave. But some people don’t care about belief, because some people don’t feel the same…some people don’t have the same emotional attachment or love or whatever it is.

Jennifer sees ‘spiritual’ midwives as people to be in ‘awe of’.

J-A(H): I admire and am in awe of ‘spiritual’ midwives… but feel I am not so I feel I do not think as deeply and can be very shallow, so someone explaining and demonstrating depth to me is awe inspiring.
Both these midwives seem to equate the role of being a midwife with 'love', another 'nebulous' emotion that is difficult to explain (Odent 2001). Jennifer also sees a link between caring and spirituality and suggests this was easier to do in a small working team.

J-A(H): I know plenty of midwives who aren't spiritual; no I wouldn't say plenty but I do know some midwives who don't care. So spirituality is equated with kindness, ability to love, ability to verbalise that...I think to be spiritual if loving and caring about people was much easier in a small team and I think that actually reflected on the care you give the women.

Her indication here is that caring is a sign of a spiritually aware person and the qualities of kindness, love and communicating it are outward signs of this. What could be questioned is whether 'spiritually aware' midwives 'love' more or if loving behaviour is an indication of a sign of spirituality.

**Spiritual care**

In discussing the issues of the art of midwifery the midwives revealed comments regarding spiritual care and intuitive practice. These are explored further in this section. Sally-Ann is clear that the art of midwifery is a 'spiritual' aspect of her role.

S-A (C). If we lose sight of what a midwife is we lose the soul of the profession. I think the meaning of the art of midwifery, it's the essence of the job, more than the physical side of the work we actually do. I would say it's more the spiritual side we bring into it, our feelings about the type of work that we do,..., working with the woman and the family and bringing out the spiritual side of it, listening to the woman and their views and building a relationship with the woman. The spirituality of it is the relationship you build with your woman...

Such an intense view mirrors women’s views of the spiritual nature of pregnancy and birth (Carver & Ward 2007, Jesse et al 2007). Lucy equates spiritual care with religion and the need to provide care appropriate to a woman’s belief system.
Lucy (C): Holistic means caring for the **whole** person: physical, mental, social and spiritual. What is spiritual? ...I think that is very much dependent on the client but maybe with religious groups to do with religious beliefs. It may just be their personal beliefs but at the same time I don’t…feel that it’s my place to question their spiritual beliefs but it is to support them through whatever their actual belief is…and if it’s something that you don’t have an awful lot of experience of then you ask them in a non-threatening, non-judgemental way in order to help you understand how you can help them. In some respects possibly recognised religion is easier than personal spiritual beliefs…but I think it’s wrong to pretend you know all and then find you’ve put yourself in their eyes in the wrong through lack of knowledge…I suppose… you also have the extremes within each particular religion, so again it’s always worth establishing people’s spiritual beliefs as to exactly how they practise…even in a recognised religion you can’t tar everybody with the same brush… It’s paramount to consider the individual.

Lucy is clear that good spiritual care begins with an individualised approach and asking about beliefs. This is a challenge as currently there are no formal spiritual assessment tools for pregnancy though we are expected to teach this to students (NMC 2009). Assessment will therefore depend on individual midwives to carry out.

**Instinct/intuition**

Intuition as an aspect of professional practice has been debated and discussed, in relation to whether it comes from a level of ‘experience’ or is something that is a deeper level of understanding (e.g Jefford et al 2010, Olafsdottir 2009). However, the midwives talked so much about an ‘inner knowing’ (Olafsdottir 2009), that connecting this to spiritual care appears appropriate. For Lucy intuition is related to the art of midwifery.

Lucy (H): *I believe the art of midwifery is related to instinct, intuition, underpinned by knowledge. It is about communication, both verbal and non-verbal and includes listening skills. I think art and science overlaps*
and mingles together. I think the art are the skills you have learnt, be they intuitive or response to action. The science is how things work and why they work, more of a recipe I suppose, if you put the ingredients in and it’s what comes out at the end, like a cake.

Archie views that the art of midwifery is ‘something within you’.

Archie (H): The art of midwifery to me it explains the approach that you have towards the woman and baby and the family in general. So it’s the way you conduct yourself. It’s the things within you so rather than the science of midwifery and what you have been taught. The art of midwifery is how you actually look after the woman during labour really, I suppose the baby as well eventually. But the art of midwifery to me is how you become one with that woman during labour and probably pregnancy as well if they are having problems and how you guide them through it.

Sally-Ann highlights that experience has led to her role being intuitive. She sees this as something to be valued and of significance.

S-A.(C) …after being in nursing and midwifery now for nearly thirty years I think a large part of the role is subconscious and you do it without necessarily thinking about what you’re doing and I’d like to think that I’d got to the stage in my career now where a large part of my job is actually intuitive…

This idea of care being ‘subconscious’ is challenged by Christopher Johns (2009) where he is suggesting that professional practice should be more ‘mindful’ and conscious. But it makes me wonder if this intuition that Sally-Ann refers to is something deeper than just a practice situation. Connie relates to feelings she has of an ‘inner calmness’.

Connie (H): I think it’s something a lot of midwives have. They don’t necessarily find it and I think they are frightened of it. I think you have an inner calmness because you just accept, I accept. I think fate to a certain extent. A lot of things happen and it kind of wouldn’t matter what I did...
that would still be the outcome and all I am is some sort of conduit to get to the end really and so if you feel like that then you can be quite calm.

She views here that she is a ‘channel’ to help the woman get to the end of labour. This calmness is also expressed by Lizzie however she also recognises a cognitive skill of knowing when to intervene.

Lizzie (H): I think… it’s the adaptation of what you need to do at the time. I mean I don’t panic very often, I think of myself as being quite calm but you know I do step in quite quickly when I have to, so I will stand back until I have to…it maybe that I am letting the woman take control until I think no that’s it, change of plan, we’ll do my rules and we’ll adapt that way. But I think its finding the right time to do it. So it’s something about the skill of being able to know when you have to step in.

For both these midwives there is an internal ‘knowing’ about when to react and ‘do something different’ rather than let nature takes its course. Connie agrees that the art of midwifery is intuitive.

Connie (H): The art of midwifery is to me is intuitive practice; of understanding the process of pregnancy, labour and birth and helping someone through that in the coping mechanisms and different methods and trying different things to actually get a positive outcome that can be remembered as a positive outcome regardless of mode of delivery. For me the positive outcome is a …not even necessarily healthy, a live baby and a family which you anticipated… the art is whatever they experience; whether it’s no baby, a healthy full term baby, a premature baby, a baby with perceived defects, that they go away feeling as good about the whole situation as they possibly can.

Mary D is clear that this intuition comes from experience of the person and that the art of midwifery is specifically related to a natural birth.

Mary D (H): My concept of [the art of midwifery] is the fact that it’s away from the science of midwifery, its away from the theory, it’s actually the art of caring and supporting a mum through labour using your intuition and your tacit knowledge and your experience to interpret her body
language, signs, all sorts of things, enabling you to care for her. That sort of intuition of how things are going; there is something there that you know from your experience and the art is actually supporting her through a natural birth…

I asked her to explain what she meant by intuition.

Mary D (H): Its difficult [to define intuition… you just know from experience don’t you…you know, when you see somebody come in you think ‘she’s in labour or she’s silently doing something’ …there is something from your wealth of experience that you can pull on to know what things are at. When you examine somebody you know if they’re going to have a reasonable labour or not; it’s that sort of experience. It is from knowledge but it’s from your experience too… something that you can’t actually define- but it is obviously from something tangible like when you know somebody’s coming up to fully, you know that, from the body language, and the signs and from your experience of seeing it before.

Lizzie agrees that experience is key.

Lizzie (H): I think there is a lot of intuition as well that comes with experience… so that you just get a feeling when things aren’t going right and you know …alright there is an expected normality and sometimes you know where the boundaries lie and sometimes you can just go over the boundaries and still get there… you just have to try the perimeters…

In a community setting Lucy views that intuition is picked up through communication and knowing the woman’s home circumstances.

Lucy(C): If you are in their home environment [there are] things that would perhaps give you clues towards the lady, perhaps as to what her likes and dislikes may or may not be. So something within you can…help to direct or to make sure that they’ve got all the information to make choices so that they are making informed decisions… I think it is something there that you use but you don’t necessarily realise how often
that perhaps you’ve used it or you are using it until something happens to you (laughs).

In a hospital context Jennifer A highlights that it is difficult to be intuitive if you are not physically ‘present’ in the room.

J-A(H): We do know a lot, we do look at the women, you do…but if you are not in the room and she’s got an epidural then how can you be reading all these signs and knowing what she really needs?

Kerry in the community also recognises that intuitive practice is easier when there is a relationship with a woman, but that it isn’t always the case.

Kerry(C): I don’t know where this intuition comes from, I really, really don’t know. Other occasions happen and you think, right I’ll just go and see that person today, coz I know, something’s telling you to go and see that person; somebody non-attends for a couple of weeks and you think I’m not going to follow the procedures with this, I’m going to go and knock on their door coz something just isn’t right. I don’t know if everybody has that. I think it’s very spiritual and I think it’s very much knowing your women. However the home birth I was at last week I’ve never met that woman before in my life, so that contradicts that doesn’t it?

She is saying here that at times there is ‘no known reason’ for why she does things and calls this ‘spiritual’. Archie also talks of this ‘feeling’ that something is not right and suggests there are some who have this ability more than others.

Archie (H): And also part of midwifery in general you get a feel when things aren’t quite right but you may not know why. It’s like an inner feeling, which partly comes from the more practice you have and the more experience you have… Some midwives have got it more than others. I think some people are more switched into that kind of thing anyway…as you watch other midwives practise it becomes more interesting because it becomes more and more apparent. I think that…it affects the way you are or the way you can deliver your care. It’s quite
Kerry views there can be telepathic responses between midwives who work with each other.

Kerry(C): Intuition is just a feeling that you have when I suppose you’ve got in the back of your mind you know all the theory of midwifery, all the policies, all the procedures that you are following and that is up here in your brain and you are knowing …realms of normality and all of that but something is just telling you that it’s not quite right and you can’t explain it at all. But looking at that [second] midwife last week I knew she was thinking exactly as I was thinking…It was a kind of telepathy in thinking, right what are we going to do now, what are we going to draw on from our skills as midwives to get things going right?

Kerry here is talking about a deep connection between midwives. Archie also talks about deep connections between midwives and the women using an illustration of a birth in a home setting where she was second midwife.

Archie(H): I ended up looking after the husband and trying to calm him down and ended up almost taking him down to the level his wife was but the interesting thing was that I observed was the other midwife because she was so in tune with the woman she didn’t even notice that she was doing it, so I thought that was a true art because she was so with the woman and calming down and keeping her in her meditative state that it was brilliant because they were almost… engulfed in something that wasn’t there on their own and he was just not an issue… and the midwife was totally not aware…

For these midwives then intuition is a significant part of the art of midwifery. I was interested to know how they felt they obtained this skill as Kerry states above she does not know where this ability comes from. Sally-Ann feels intuition is something that is learnt, but then suggests that some people have a natural ability to be intuitive.

S-A(C): It’s a mixture of [something you learn or that comes with
experience and something in some people and not in other], all three I think (laugh). I trained with a midwife who had all of those three... The holistic approach to care came naturally to this midwife; she didn't have to think about it... she just knew. She just had that natural ability so I think, for myself, a lot of has come from nearly 30 years in the health service, working as a nurse and a midwife. I think. ...a small part of it is learnt, but I think a lot of it is intuitive. But there again I think you do get midwives, it is just a natural ability that they can do it.

Connie is also mixed about whether this is something you learn while recognising there are some with a natural ability.

Connie(H): sometimes you do certain things with certain women because of how they are interacting with you, of what their expectations are and I think that you use something inside you to accommodate lots of different influences coming in to your room at the time. I think...this is something that comes from experience, although I would acknowledge that I've worked alongside some midwives who don't have years of experience but do seem to have a natural ability to provide care that other people never seem to acquire. I do just think some people are born with that capability to look in a room and see that someone needs something... I do always feel I am very aware of how people feel and could walk into a room and very quickly know if something wasn't right and it's always been like that since I was quite young and very much remained that way.

Though Connie believes intuition is learnt she is indicating here there is an instinct to care inside her that she believes that she has had since a child. I reflect too this has been part of my journey and may be related to the sense of vocation about the caring professions discussed earlier. For Lizzie intuition is learned and from midwives being willing to learn.

Lizzie (H): … From my point of view I think women’s intuition comes from experience and a lot of colleagues I respect they work intuitively. But I think that comes with being willing to learn and constant learning and if you are willing to learn be constantly educated and learn from
experiences then your intuition develops a lot better than people who aren’t willing to learn and put the shutters down.

Lizzie is indicating here that in order for intuitive art of midwifery care to take place the midwives themselves need to be open and willing to develop and learn. It is evident from these comments that these midwives believe intuitive practice is relevant to carrying out the art of midwifery.

**Spiritual nature of birth**

The process of birth is often mentioned as a ‘miracle’, by those who are part of the event. It is a period of transformation from one state into another with the creation of a ‘new life’ in most cases. It is therefore perhaps not a surprise that for some of this group of midwives being the midwife at a birth is a key spiritual event.

Kerry (C): But there must be something… I don’t see myself as religious at all but when you are bringing a baby into the world there is something isn’t there that it is just unique and fantastic and extremely special about that time and…it would be sad to think that there wasn’t something more there, be it whatever…this is truly deep, sensitive and joyous and celebration from pregnancy to birth and I think a woman’s body is quite amazing to do that really.

Archie (H): I still do cry every delivery, I think it’s fabulous the whole process is just so emotional and humbling, it is lovely. … Basically [spiritual] is what divides it as a job from other jobs including nursing. It’s something inside you. As a midwife it’s not a religious feeling but a magical feeling, it is more feeling from within and an atmosphere, more than a religious spiritual process, more a miracle, the magic of a new life; the same as sitting with someone who’s dying as well, because I have done that as well …but I think the bright lights and the noise and the chat and too many people in the room takes away that spiritual feeling of the baby and the mum welcoming a new life. …The magic of birth is lost in the theatre or more medical setting.

However Jennifer states that birth is not always a positive spiritual event for women.
J-A (H) Not all women view it like that though; it isn’t deeply spiritual for some people... It can be a horrific experience for some women... when they have to have psychological support as well, where there’s dysfunctional relationship, where the baby’s not welcomed, not wanted... It’s not a deeply spiritual moving experience for lots of women for relationship reasons maybe; maybe she doesn’t want the baby, maybe she’s mentally ill, drug abuser... where they have had a really bad experience and they are not enjoying the labour, where they have been taken for caesarean section at 10cm and they don’t want to... have a connection with the baby, which actually affects their relationship with the baby later and some women have to have psychological support don’t they? They should have more spiritual support...

She does not explain what she means by spiritual support but she seems to imply this equates with psychological support. She goes onto suggest in contrast that for women with an intense situation such as the death of the baby, these women gain some spiritual strength.

J-A(H) I think...back to the woman who has got the IUD because she’s got that greater need, she’s got that spiritual need, she’s got almost that from somewhere, somebody from somewhere helping me and has she moved onto a different level because she has that desperate, maybe even a religious need then? It’s got to be something out there to help me...

She indicates that different women have different levels of spiritual resources for challenging situations. Part of a midwives role therefore is to recognise this and provide any extra support that is required.

8:4:6 Social context of midwifery

Midwifery is a role where there is continual contact with people and is not an isolated job. Historical midwifery took place in the heart of the community, where women, seen to be wise, were regarded to be the one to help bring babies into the world, to look after the sick and to lay out those who had died (Donnison 1988).
These women were usually without the ties of family (though not always) but were generally ‘available’ to anyone. When I started nursing training in the 1970’s there remained a legacy that nurses would not be married, but committed to the career, and there were a number of spinster sisters who lived on the site of the hospital and were ‘available’ in times of crisis. When I trained as a midwife it was rare for anyone to work part time. Currently, figures for midwifery in the UK show that fifty per cent of midwives are now practising part-time (Midwifery 2020 workforce workstream 2010), which alters the working contexts for these women.

**Balancing personal relationships**

As women with caring responsibilities these midwives need to balance being a midwife with the needs of themselves and their families. The choices the midwives make about career are related to their family needs.

Lucy (C): *Over the years I have had to make compromises, trying to balance work and home.*

Connie (H): *One of the reasons I came back into the hospital was because I personally give too much at times for my own family’s wellbeing and do provide that holistic care where I am interested in everybody and making sure everybody gains something and there for support. So consequently at times I wasn’t necessarily at home when I should have been So that’s when I made the decision, when my children were younger, to come back into the hospital where I could walk in and walk out. For a little while that was great, you know I came on duty and walked away and actually now I’m finding that more frustrating again.*

Archie (H): *I ventured back in to the Hospital after 2 years on the Team, as my family had suffered enough of my never being home, and when home, constantly talking on the telephone.*

For these midwives the demands of working in the community areas had an effect on their family situation. Pamela suggests her family commitments limit her commitment to being a midwife.

Pamela (H): *It made me think deep within myself what my fears are in*
midwifery, the respect I have for the job; how on one level how much my job means to me, how constrained I am (as I have a young family) with time. I can only work a limited amount of hours and I can’t necessarily be involved more within the dynamics of the profession and work… I think I am constrained by the short hours that I work – I have to leave at a certain point to collect the children- I have to go- so actually in that short 7-6 hour time frame I think what do I do? Sometimes I don’t deliver a baby in the shift- what do I do?

She is trying to make the best of the situation and be committed while she is on duty. In contrast Jennifer sees being a midwife is important for giving her time away from complex family situations.

J-A(H): My job is what little I do for myself. Everything else is for my kids, husband, family friends etc… I am always busy with my family, husband, friends… and after a long day at work find limited time to reflect or explore the person, women or midwife who I am. This depth of feeling usually leaves me feeling depressed, fearful and unfulfilled so best left alone. I keep myself busy so I don’t have to think…and I really feel I don’t take my personal life to work…that’s my escape then…I feel like I achieve it, I feel like, oh well, you know, my escape has worked, have a laugh, have a joke and there are some tremendous women up there… and some women that will really inspire you, fantastic midwives, for all different reasons, and there are some who are not so nice.

She appears to gain, therefore, from the personal contact with the other midwives who boost her morale. Others identified the benefits of working with others in the community.

Connie (H): I think we do work very much on our own and you learn so much from actually working alongside people and I would say that I learned more about midwifery in the four years I did group practice and community work…there was six of us that worked together and because we needed each other and we did a home birth rate up to 20% I learnt more than from other midwives than I ever have learnt in delivery suite…
Kerry: … Other midwives are different… I do enjoy working with other midwives, [seeing how others cope] yes coz you don’t get other than being a student do you?

However Jennifer also gives a conflicting view about the difference between working on the community and in the hospital situation.

J-A(H): On community we were very close on team, very close, and it was obvious when there was somebody who didn’t want to be there because it impacted significantly on everybody’s relationships and some characters could cause an awful lot of trouble… but I developed very close nurturing relationships with my colleagues and I still see them all now. [On delivery suite] I don’t think anybody wants that relationship there. I think it’s quite a cold place to work actually.

On one level she sees work as an opportunity to ‘get away’ from home. However it appears that this is not enough to fulfil her expectations of support and friendship. She continues by saying that the main place for support should be in the family, which contradicts her previous comments.

J-A(H): But women [constantly give] don’t they?... My husband’s life and my life is very different and I feel I’ve got a very nice husband. But I see lots of women, not supported…I think that’s the main people who give you support because if you have a bad day at work you shout at the kids and you are ratty with your husband and the support has to come from them; and when you’re tired you can’t go to work and say, oh I’m tried, you just go home and say you are really tired don’t you. You say to the kids oh I’m really tired I don’t want to play that now, go. So who are we giving it to really? We talk about all this love for these women and, you know, we need to look after our self as well don’t we. I think it’s appalling.

Kerry also recognises that she has to balance her work life with her family commitments.

Kerry(C):…And clinics run late so that runs the rest of your day late;
there’s you not getting a lunch break and then you are getting home late to your family where you are trying to juggle your family balls in the air. The balls are home life as well. I think you are juggling this and some days you are going to drop some balls and you have to in your mind think, right is it important enough to juggle and reach and scoop that ball up or just let it go? And the things that often get let go I suppose are your housework, your washing and all of that and to some extent your friends, your social life and then you hope not to the detriment of your family but … we are being pulled in two directions really and I hope this would never impact on my child and my family, but it does. You take this home with you, [the frustration and the stress and the fears of it] yes and the paperwork and the making phone calls of an evening, you take that home with you. So it’s a very, very fine line I think with wanting the absolute best for women and their families to the detriment of your family because of all this.

For Connie her work role is significant to her and her family are the key to helping her keep going in that role.

Connie(H): Sometimes you just need to step off and think ok I need a break from this and you do have holiday and I can almost feel myself during the year getting to a point where I feel my batteries are empty and I need to stop and I need to go on holiday and I need to regroup with my family and my children and actually charge up again and I think that’s because I can’t not give something over, no matter how short a period of time I am there.. I don’t feel that I don’t function at home or I’m not the same person at home. In fact if I am not at work for any length of time… and I am just at home on my holiday the family will say oh I bet you are looking forward to going back to work because I am ready.

Connie is clearly able to recognise her needs to refresh, but it leads to questions about those midwives who are not so self-aware and whether they may not get overstressed if they are unable to ‘break’ when they need to.

For some of the midwives their experience of having their own children impacted on their roles as midwives.
Lizzie (H): I was changed by having my own children

J-A (H): Many things have impacted on my practice but the main thing was the diagnosis of my… beloved daughter with [diagnosis removed]. My life was turned upside down and inside out by this devastating news at the time being 30 weeks pregnant with my second child and soon to give up work. ...I think that’s very hard- I don’t think a woman can give birth to a child and it not affect you…

Connie (H): ...maybe it’s from personal experience; I have had an unsuccessful pregnancy where there was no baby and that to me was devastating so for me as a midwife I still feel that devastation…if that happens to them but it doesn’t stop me caring for them and feeling able to care for them…

Despite experiencing a painful situation Connie recognises her feelings in that experience and is able to be empathetic to others in similar situations. Research evidence shows that for other midwives a poor reproductive history may make continuing in the role a challenge (Bewley 2010) with potential effect on their care of others.

The importance of relationships with women

Some of the midwives related that ‘being there’ for a woman is an important aspect of their role.

Pamela (H): If things are going a bit pear-shaped, as long as you are there and you are the constant in the day… they can get there really. It is really important for me to remember why/who/what is important in the evolving birth process- the woman- the relationship- the baby and the being there, helping/facilitating it.

Lucy (C): Establishing relationships is down to communication…not only verbal but being able to read people and understand what it is they are giving you as silent communication…and…maybe as you are establishing relationships it helps you to phrase your questions or things
you would perhaps do in a different manner depending on how well you know them. You know the people you can ask serious issues to in a straightforward manner and you know others that perhaps you have to kind of build up to it… you kind of get to know the ones that are the worriers, the ones that are quite relaxed, but you know that if they phone you there’s a problem, you know…as your relationships establish. But you can only establish a relationship by being encouraging and supporting and communicating and being there.

These midwives therefore see their role as standing alongside women, the ‘with woman’ that the word midwife means, whether within hospital birth setting or community. Lizzie suggests that there is a difference in the relationships with the midwifery role for some women.

Lizzie (H): some people will labour without you being there… you are there, listening in, you are doing what you need to do but they will just get on with…a normal process and you are being there because it’s a legal obligation… I think they could deliver quite safely possibly without you although I do appreciate you do need that comfort that there’s somebody there for you but I think… you are sometimes just being there with people whereas other people it’s not just being there its being there and doing.

Here Lizzie is suggesting that in totally ‘normal’ situations of birth the midwife maybe in essence in the background, just watching the process unfold. Perhaps in these circumstances a strong relationship with a midwife is not required. I am very struck by her last statement about ‘being there’ or ‘being there and doing.’ and reminded of Marsden Wagner’s (2010) statement:

Rather than needing to do something, midwives might be described as those health professionals who have good hands and know how to sit on them.

The concept of the meaning of ‘midwife’ as being ‘with woman’ is recognised by these midwives as they focus on the importance to them of building relationships. The continuous relationships in the community with women are seen as significant.

Kerry(C): I did love hospital midwifery, I did, but my main love is
community because you get a relationship with the woman and her family. If you are just a delivery suite midwife then you might only meet that woman for 8 hours of your shift. The next day she’s delivered and you’ll never see that woman again so I think that does have a strong impact on where you work …I think its job satisfaction really… and knowing women. Not that you don’t get job satisfaction; say I am going to see a woman today that’s got breastfeeding problems and I can help her with her problem by the time you leave that visit that woman’s got the baby on the breast beautifully feeding. I suppose you do get job satisfaction from that but I am probably never going to see that woman again and I think it’s just me I don’t like that dipping in dipping out type of feeling.

Archie agrees that building up relationships is more difficult in a hospital setting and could be related to personality.

Archie (H): The fact that I am working in a hospital environment and that relationship is difficult to start with because I haven’t met that person before definitely has an influence. It depends on the kind of personality you are doesn’t it coz I do tend to quickly build up relationships with people and am able to do that …and I do feel I can build up relationships with a lawyer one minute and a [name] estate drug user at [the next].

Many of the midwives discussed the differences in building up relationship when working in the community and in hospital units.

Archie (H): In the team generally I met most of the women, yes you can build it up and they gain your trust during antenatal appointments and things and get to know you as a person a bit more. So there is a definite difference.

Lizzie (H): There is a difference in the art of midwifery in the community and from the team aspects…you do get to know your women. You can converse with them and because you generally built a rapport with them. With a lot of the women you know how they work. In the team aspect, we had six midwives and although you may not know some of the
women very well because you’re communicated with as a team you know you can alert people if you knew they had a problem… I mean we used to get …one particular woman who used to ring us every Monday at about the same time. She would be on the phone for about an hour and a half or try to be and you would coax her through it and that was her way of coping with weekly issues or queries. We sort of got used to it so we knew how to talk to them and knew how their minds worked you know their support mechanisms they may have.

Conversely there is an art seen in hospital settings of building up a relationship of trust in a very short space of time.

S-A(C). I don’t say it’s impossible within the hospital setting…and we all know that you can take over the care of somebody and at the end of your shift they’ll actually turn round and say ‘thank you very much, it was much different’…but when you have got the time and you see somebody more than once it makes it, facilitates it…it’s easier than trying to do it in a short period of time but then I’m sure we are all different aren’t we? There are midwives I am sure who are much more able to use the art of midwifery in a much shorter amount of time than others. It depends on what sort of person we are, doesn’t it?

Lizzie (H): …There is an art to it, you know and a different sort of approach. I think you have to be speedier… Instead of saying hello how are you, letting the relationship evolve…it’s a fait accompli, you just get on with it. And I think women who choose hospital deliveries do tend to accept because that’s what they know is going to happen. You are going to meet a midwife and she’s going to deliver your baby. Usually you have the time to build up a relationship, usually you have a couple of hours, …or it might be they’ll go home and then come in and you’ll see them again, but it might not be, you might just have 10 mins and then they deliver and …then rapport is built up postnatally, post-delivery, which does happen quite a lot unfortunately.

The midwives here indicate that there is a different art to developing relationships quickly than those that grow over time. In an ideal situation a continuous supportive
relationship is viewed to be the best for women and easier for midwives to provide care (Hodnett et al 2007). However Pamela also highlights that this may not be the ideal for all women.

Pamela (H): …everyone is different …I don’t think it always works well for the women. We have a couple of women in (team area) who had the traditional midwifery system in previous pregnancies and they didn’t want to know the midwives who looked after them in labour. They had a relationship with them and they would be embarrassed on how they behaved in labour… and they think they will never see you again after you have looked after them so if they make a complete fool of themselves and embarrass and shout and call and scream and everything they don’t have to see you,…the next week (laughs). You know, whatever systems we use I don’t think we are going to get it right for everybody really.

The implications are to recognise the individuality of each woman and to see that the art of midwifery is about establishing relationship in whatever situation the care takes place. However, the midwives were more likely to see being a community based carer in the context of the social and cultural environment of the woman and her family.

S-A(C) Holistic care is very important to me but I think we need often to take it one step further and have a salutogenic\textsuperscript{14} approach to our midwifery role because it’s not just the woman and the baby, it involves, not just the baby’s siblings, and her husband, but quite often grandparents, and other relatives and in the ever changing way of the world, it’s not necessarily what we would think of as a nuclear family. It could be that they have got a female partner or you are supporting a foster parent, so to me the family is almost, not the most important, but as important some times as just the woman and the baby.

Kerry(C): you have all the national frameworks and guidelines to follow

\textsuperscript{14} Salutogenesis or the concept of the ‘generation of well-being’ is based on the work of Aaron Antonovsky. These concepts are further addresses in chapter 9.
just specifically for antenatal care. But you can’t follow that in my area because a woman, when she comes to see you, that’s a fifteen, twenty minutes that’s solely dedicated to her and I think you have to make that woman feel special and you have to have that time in communication with the woman because she will go back to her really dire life with…three kids and the husband being unemployed and living in the high rise and living in a terrible part of [the city]…So from my perspective working as a midwife there is definitely very much a public health kind of role…I think public health is a huge, huge agenda be it your drug problems, alcohol problems, smoking problems, be it to genuinely poor people that have no money for anything and genuinely can’t work and to those that won’t work and to those that are seeking asylum and from a war-torn country and carry a lot of baggage from there that you are having to unravel as well and need help with, you know, their status and housing and all sorts of things really and just arrived pregnant in the country- don’t speak any English…

Archie (H): Many of my caseload were very vulnerable teenagers/drug users and women in poverty, so many of my days off were used scouting around for old prams/baby clothes and phone calls to housing associations/social security departments to hurry along accommodation problems…

The public health role of being a midwife has often been overlooked. However, a recent report and guideline will reverse this trend (Chief nursing officers 2010, National Collaborating Centre for Women’s and Children’s Health 2010). For these midwives the aspect of being part of a community of women and meeting their needs is significant. Here they indicate that the midwife is to be a facilitator and not necessarily to be about her building up relationship with the women (Leap 2010). Connie also talks about the importance of including family in the process.

Connie (H): In a home birth we would perhaps be in the kitchen and they would be in their lounge or their bedroom or wherever they were or we might have been making food for them, you know, providing sustenance and we would be talking…with the Granny or the other children would be pottering in and out. It’s much more relaxed and not this feeling of need, you know it’s almost you can see the fear in their eyes sometimes, the
need for you to be there and make it alright.

The wider family is more significant in the home. Connie also talks about the issues of communicating with partners.

Connie (H): I think some women need their extended family around them, they need their partners, other women are stronger and would…rather be with a midwife. But society now has pressured the situation where men do come all the time; it’s not so easy for them to step off. One thing I always said as a community midwife when I did the birth plan, I always liked the partner there and I always, always really wanted to hear from him that he wanted to be there…and I wanted her to hear. We…almost made like an informal contract decision between us as a three that if he chose not to be there that’s going to be alright and she must respect that as much as he respected that she would quite like him there. Interestingly when you give people some permission to leave they do go.

Connie is mentioning here concerns about the presence of the male partner in the birth room. She highlights here that it is important for midwives to build up relationship to enable partners to make the right choices for them.

Jennifer points out that midwives don’t always get on with partners as well as the woman.

J-A (H) But what about the woman that you don’t feel that you have connection to, what about the woman that husband irritates you? You do get them don’t you?…And you try to be professional, but then you do get women where you come out of the room and you go [makes face] because that can be difficult and I am sure the women think about the same about you.

Jennifer perceives that women are less likely to complain about team-based midwives.

J-A (H): And its quite interesting, as team midwives, there’s hardly any
complaints for the team, but there’s complaints from the hospital, a phenomenal amount.

She relates this to the perceptions women have of the midwives.

J-A (H): …any midwife who has come out on the team I’d say ‘whatever you do the first time you meet that woman you’ll never ever be able to come back from that at all’. If you are nice, or…if she’s has caught you on a bad day where you are really short or whatever, she’ll never forgive you for that, ever. And you’ll never be able to redeem yourself, ever, they are totally unforgiving, pregnant women…obviously certain women will be drawn to certain midwives and you can see that, certain personalities and they come in and say ‘I don’t like her, the other one, I don’t want her near me’ yet she’s lovely, what are you going on about? … it was just that they preferred certain personalities and that is…in all walks of life, isn’t it. You’ve got a GP surgery with 8 GP’s- you say ‘I don’t want…I would prefer to see that one’. When you have teachers at school, you have parents evening…or curriculum evening, and all the teachers are standing and you are thinking ‘I like her and I don’t like her’ we are very judgemental, aren’t we?

The implications of women not getting on with a midwife is resolved by independent midwives who view the initial booking occasion as a place of ‘interview’ for the women (Cronk 2010). In this situation the association is a business relationship where the midwife is ‘employed’. If the woman does not like a midwife she can, in effect, sack her. In the NHS women are not so fortunate. Usually a woman is allocated to a midwife and remains in this situation unless a formal complaint is made, which is stressful for a pregnant woman in a vulnerable situation, and for the midwife.

Kerry highlights some of the challenging issues of working in the community.

Kerry(C):…. then also there is the other skill that you are sat with a Social worker in a house. People aren’t doing what the courts asked them to do and you know they are aggressive toward you so that’s another skill, just very much an observing skill I’d say to then go back in write reports
about how people have been, so it’s not always the lovely normal, wonderful pregnancy and childbirth that you are dealing with because all people aren’t like that.

It is significant to the art of midwifery if the midwife and the client are able to build up a suitable working relationship. The implications here are whether midwives are able to recognise when a relationship with a woman or her partner is impacting on the progress of the pregnancy or birth and then whether she is able to do something about it. Archie takes this further by her view that being a midwife equates to being a ‘mother’ to women.

Archie (H): I think anyone in pain is very, very vulnerable and when you are in pain all you want is someone to understand that pain and help you with it or help you through it and so that’s a hugely mothering role in the sense of the word mother isn’t it, a hug [laughs]… I think most women love mothering, I think most of them want it. You know don’t you if you try to put an arm round someone you’ll soon learn that’s not what they want, if they’re not a touchy sort of person…

This is an interesting concept as not every woman wants to be ‘mothered’ particularly if they have had poor experience of their own mother. The intensity of the relationship is balanced by Kerry who mentions times where the continuous relationship can be too demanding on the midwife.

Kerry (C): I have got women on my case load who drive me crazy as well so at times you are thinking I can’t wait to discharge that person and you know all midwives have that thought. I am sure that these women obviously needing a bit more from you but dip into you more so than others. So there are times when continuity from my perspective isn’t good, yes, but I think it’s still good for that particular woman.

Her comments reveal that, even though it may not always be good for the midwife, she believes continuity is important for the women. Being a midwife therefore involves mediating relationships with family, alongside balancing the relationships with women in the arena of the social lives of these women. She continues:
Kerry (C): …In the antenatal classes…we try to be as informative as we can but my sole aim of an antenatal class is, you would think as a midwife I would be about to say prepare them for labour but it’s not, my sole aim is to make a relationship with other women in the area that they can contact before they’ve had their baby and after they’ve had their babies. We’ve had some fantastic friendships come from those classes. To me I feel that’s what we are doing well. Not necessarily about reducing the caesarean section rate or promoting normal birth right down their throats… we do, do that but as a midwife my main aim is for them to be making friends in that class and the dads as well. Because they do come, the dads and you know in the area we don’t do any evening sessions because it’s not terribly safe for us to go on our own down there so they are in the afternoons. But you’d be surprised the men do come and how many men on benefit come.

For Kerry she sees her role in the community is less about creating a relationship but about enabling the women and partners to create strong relationships in their community that will support them. There is clearly difference in the way these midwives individually view of the relationships with women they care for.

**Trust and lies**

In addition to the general issues of relationship discussed above the midwives mentioned the concept of trust as a significant issue within the art of midwifery.

Kerry(C): This is something to do with trust; I think that’s’ a huge part.

Sally-Ann also discusses trust in labour when talking about the photographs in the montage she had created.

S-A(C). I think that to me the midwife holding the ladies hand in the pool sums up for me what the midwife’s role is especially in the labour situation. There’s just that look of trust there; that woman has placed herself completely in that midwife’s hands and it looks as if she trusts the midwife implicitly with her labour and her birth process. I have done water births in the home situation and they’re fantastic…working in the
hospital as well it is achievable, but you almost have to...perhaps to work a little bit harder to achieve that trust… I think at least if you are meeting somebody in the home, taking them all the way through the pregnancy and hopefully doing their home delivery as well, you have built up that rapport that trust, two-way communication.

Sally-Ann relates here how the woman puts her trust in the midwife but she also describes a two-way process; that the trust needs to be mutual. As discussed previously the development of trust may be easier within the community where women have more time with the midwives. Lizzie talks about being on a team in the community and awareness that women discussed the midwives as much as this took place in the teams.

Lizzie (H): You know some of their concerns. So that when you went into delivery you were aware of a lot of them and they trust you, they are a lot more relaxed with you. They will work with you because they have a trust in you because they know you. Even though they might not have met you they’ll have heard of you because these women get together in their little coffee mornings and they talk about you and they will talk and compare.... So you had that both sides of feedback. We talked about them. They talked about us. But in the nicest possible way and then postnatally because they trusted you they would then reflect and feed back to you on what they did like and what they didn’t like and I think because you had that trust initially you had the trust with them in labour and if things didn’t go right they worked with you. I think the danger is in delivery suite when people walk in and they are scared.

Connie suggests that the art is about mutual respect and confidence in women’s bodies.

Connie (H): I think that you provide confidence, you build confidence in people and that would be both midwives and mothers with normality by respecting their bodies and for midwives to respect the women and... I think that if you are confident in the way you support them, then their confidence grows and the women’s confidence grows because they feel looked after and cared for and they feel safe.
Connie is suggesting here confidence and trusting relationships appear to go hand-in-hand. However it is of concern that, instead of trusting relationships Jennifer is adamant that in practice situations midwives ‘lie’ in order to either protect the woman from intervention or to ensure doctors intervene.

J-A (H): Midwives do it all the time, tell lies yeah: ‘you are pushing really well’ when you are not. ‘You are doing really well’ when they’re not. You… know that somebody might take a bit longer so you underestimate the VE\textsuperscript{15} by a centimetre so it gives you a little bit more time. You tell the doctor …if you know she’s not going to do it, because intuition comes into it like we’ve talked before- some women with the best will in the world they’ll never push their baby out, they’re tired, they’re exhausted, and they’re pleading with you, so you tell the doctor she’s been pushing 15 minutes more than she has or, if you want a bit more time because you know she’s going to do it you drop it back 15 minutes, and it’s well known in practice that midwives do that. You give yourself a little bit more time or you give the control back, because otherwise you have got people knocking on the door; ‘what are you doing in there? Have you ARM’d\textsuperscript{16} her yet?’ So you tell lies.

Jennifer also suggests that midwives are more likely to be ‘honest’ in the community.

J-A(H) you are really honest because at some point, if things do go wrong you would have to move off, you would have to go into hospital and she needs to trust. I think …that it’s purely for the medical staff that midwives lie, to buy themselves a bit more time, to cheat the partogram, to think ‘oh she’s nearly there now, she’ll do it’ so providing everything’s ok, providing there’s no fetal compromise of course- but the midwives will do it. And even midwives will do it to midwives.

These issues have been written as ‘doing good by stealth’ (Kirkham 1999) in order to protect women. However this has a significant effect of trust in relationships.

\textsuperscript{15} Vaginal examination performed by midwives to assess progress in labour
\textsuperscript{16} Artificial rupture of membranes: midwives can carry out this procedure in order to expedite birth
In this section the midwives raised significant issues. These will be discussed further later in this study.

8: 5 Using creative inquiry

This study began with the participating midwives being involved in an educational session that included creation of a piece of art. For the second interview they were offered also opportunity to create a second piece, this time using photographs and words relevant to midwifery practice. The midwives were invited to discuss their feelings about using art both as an education tool and for research. This section explores the created pieces they made, followed by their views of the session.

8:5:1 Looking at pictures

Examining the pictures the midwives created in both the education session and the second interview provides another dimension to interpreting the material.

8:5:2 Interpreting the first pictures

As previously indicated the creation of the first pieces was in a group setting, where they were given a different art material and invited to make something showing the meaning of being a midwife in ten minutes of time. The pictures they made are in Figure 8:6. In a previous study I was involved in (Hall & Mitchell 2008) we carried out interpretation of similar material using a framework by Rose (2001) (see Appendix 4). In this instance I intend to just focus on a brief overview of the pictures together as a whole, rather than interpreting individually, though this is potentially another way of examining the material.
Figure 8:6 Looking at the first pictures

Lizzie

Sally Ann

Mary Dix

Archie

Pamela

Jennifer A

Kerry

Connie

Lucy
Colour

On initial examination of the pieces together it is evident that most of the midwives have chosen the colours of pink and red in their pieces. This of course may have been influenced by the materials provided; however on the day there were a variety of colours of paper available to choose. Pink is regarded as a particularly ‘feminine’ colour (Sparke 1995) and the choice of pink by the midwives may reflect their consideration of the ‘feminine’ nature of the role. Red is often a colour that is used for ‘danger’ or ‘blood’ or ‘fire’ (Kandinsky 1977: 24). The colour red has been used for three of the backgrounds and symbolically for images of babies, hearts and question marks. Though a potential suggestion of danger the midwives could have been attracted by the shiny paper that was also red in colour.

Images

Five of the pieces included images of hearts. This is usually regarded as a symbol of love in our cultural setting. The midwives may see love as a key factor in their midwifery role or that the result of a ‘loving’ is the birth of a child. Lizzie’s image of a broken heart demonstrates that being a midwife may also be a sad role when serious events may take place. Tears are also represented on two of the other pieces. It is also of interest that Jennifer’s heart is truncated at the bottom, which is an unusual image. Four of the pieces carry images of women and their babies, demonstrating the midwives see the women as central to their role. Images of nature are also used: sun, rainbow, the earth, representative of new life and the connection with the wider world. All these images were represented in the work completed by students in a previous study (Hall & Mitchell 2007). Two of the pieces contained images of the midwives’ hands, and the ‘holding’ of the women and babies. Such images represent protection and providing comfort.

As a form of interpretation the images alone carry a different multi-dimensional perspective. This is enhanced by the comments the midwives made themselves of the pieces (Figure 8:7- Connie did not provide an interpretation).
Figure 8:7 The participants explanation of the first pictures

*Pamela*: I made this picture as hands are important to ‘deliver’ babies; this hand is mine. The heart is mum and baby together indicating love. I used glitter to symbolise how magical birth experience is and how awe inspiring it is.

*Mary Dix*: The picture I made [laughs] was the baby wasn’t it and that was all the aspects how a midwife feels, happy, sad, saint a halo of some description, I don’t know why I put the question mark, learning possibly and the ultimate goal was that so a midwife goes through all that to get to the happy event, there are tears there as well.

*Kerry*: fulfilment in my career. Brightness, commitment in caring for others. Happiness

*Sally-Ann*: This picture shows hands that represent myself as a midwife surrounding, nurturing and protecting the mum and baby.

*Jennifer A*: The heart represents kindness and love and the bow represents being nice and a lovely person. That’s what I want to be known as, a nice kind lovely person- midwife. The sparkles represent vibrancy and laughter, ‘a spark’, fun. I don’t achieve this at times but sometimes I do.

*Lucy*: The picture shows happiness, wholeness, rewarded, complete and satisfied. The blue at the bottom shows ‘it doesn’t fall out’.

*Archie*: Nurture women and children. Educator in women’s and children’s health. The bigger picture-Global perspectives

*Lizzie*: This is a ‘Pandora’s box’, representing all types of situations and midwives.
Jennifer's piece is particularly unusual in that she provides a piece with a soft pink heart covered in bows and glitter. Yet verbally she provides a different view of herself.

Jennifer A (H): *I would describe myself as ‘non-fluffy’ however I am straightforward and find it easy to give praise and genuinely love some people. I admire and am in awe of ‘spiritual’ midwives and ‘fluffy’ people but feel I am not.*

Later in conversation she states:

Jennifer A (H): *Well I think we are quite fluffy; I’m gonna have it, I’m fluffy! I want it down! It’s being warm and well, you know… wanting to be there, open*

This is a stark illustration how the created piece showed a different side of her that she was keeping hidden. Through discussion she became self-aware of this side of her personality and ‘claimed it’.

8: 5:3 *Interpreting the second interview pictures*

In the second interview the midwives used pictures and words to create a collage. These are presented in figure 8:8.
Figure 8.8 Pictures from the second interviews

Sally Ann - community

Lucy - community

Kerry - Community
**Creating the picture**

The session and brief for this activity is described in section five. The midwives either spontaneously or in response to a question reflected on this activity.

Lucy (C): *I found this picture much easier than last time (laughs). I wasn’t really expecting it- it did cross my mind it was a possibility… but I suppose part of it is having all the pictures to myself and wasn't distracted by what other people were doing either and that again there is nobody else to see the mess I have created and that sort of thing (laughs)… I thought this was a beneficial way to explore being a midwife because there were quite a lot of pictures that I related to I suppose that I can see myself in those situations and no doubt the pictures aren’t going to suit everybody all of the time.*

Mary D (H): *I felt this activity was fine because you gave me the tools to do it with… the fact you gave me pictures and ideas it was very easy to think yes I can do that, that’s part of my job…. I dived in very quickly didn’t I? I did [laughter] because I was obviously inspired by your pictures you see. I could see when you said what midwifery means to me that I could depict my job, I could see it there actually in black and white. And it’s nice because you did bring in the coordinator… because in some respects … I imagine Joe public don’t actually think of that aspect of it as being midwifery, they just think delivering babies, and how nice and how lovely and everybody says’ oh you’ve got a lovely job’ but they don’t actually think of all the hassle that goes with it.*

These pictures appeared to inspire the midwives to visualise themselves in these situations.

**Choosing the pictures**

They also explained how they chose the words and pictures. This included why they chose the background card.

Lucy (C): *The picture is sunny, bright, cheerful. They are all bright and I like them all but that’s why I chose the yellow out of all of them, anyway.*
I have deliberately kind of offset it, if you like, in that nothing’s square in this world and sometimes we’re trying to put, or it feels like, we are trying to put things into boxes… As a community midwife, I have chosen pictures that I see are midwives’ support,

Connie (H): I split it into two colours. I’ve used purple for what feels normality and low risk midwifery to me … and purple to me feels that calm side of midwifery. And then I’ve used a slightly more clinical blue for more clinical pictures

For the community based midwives their pictures related to community based work.

Sally Ann (C): I purposefully picked photographs that I feel is what I would like my role as a community midwife to be.

Kerry (C): I’ve tried to do cupped hands with all these balls juggling in the air that represents primarily work life but represents factors from your personal life as well. So I’ve got pictures here of what I see as my job really in normal midwifery.

The hospital based midwives however deliberately split their pictures.

Pamela (H): I’ve kind of broken down the pictures and I’ve looked at what the physical aspects are of being a midwife, being with women, helping her through her labour, kind of touch, closeness, working with her family, being there in close up with everybody… I just kind of thought of the environment, so it could have been in hospital… And then I’ve combined the other side of the coin… the demands of the job… The words I chose, I kind of divide them into two, like a… venn diagram

Mary D (H): I have just put … all the aspects of my job in what I see, because I am obviously a delivery suite person, the coordinator, the multiprofessional liaison with the doctors, and obviously we have got the high tech, stuff and the resuscitation of babies. But on the other side I’ve put the other part of my job is all the normality and … supporting women and being with women and down here obviously the teaching aspect …
Centralising the woman

When making the pictures some of the midwives clearly centralised the woman as their focus.

Mary D(H) *I have put in the centre, that’s the ultimate goal of um Mum, dad baby, happy ending, obviously very happy with their experience with their midwife*

Sally Ann (C) *I feel, not just the woman, but the woman and her family should be the centre of a midwives’ role and one of the pictures in particular shows the mother with the older siblings of the baby and the midwife at to me that is one of the pivotal parts of my role.*

Kerry(C): *this is what this job’s all about, normality of birth and the celebration of that I suppose. And that is very much in the centre and I see that as being the absolute outcome of all of this, the happy family*

Talking about practice

The use of the photographs and the words also stimulated the midwives to talk about professional issues. Just asking them to say what they had done in creating the pictures and why produced an outpouring of discussion (see figure 8:9).
Figure 8:9: The midwives talking about the second pictures

**Sally Ann: community**

I purposefully picked photographs that I feel is what I would like my role as a community midwife to be. Several of the photographs show the women in their own homes and I feel that that’s when you can really build a true relationship with a woman, is when you meet them in their own surroundings so that they are comfortable and that’s when you tend to get a truer picture of the woman themselves.

I feel, not just the woman, but the woman and her family should be the centre of a midwives role and one of the pictures in particular shows the mother with the older siblings of the baby and the midwife that to me that is one of the pivotal parts of my role.

**Kerry: community**

I’ve tried to do cupped hands with all these balls juggling in the air that represents primarily work life but represents factors from your personal life as well. So I’ve got pictures here of what I see as my job really in normal midwifery, supporting people at home births and labour, talking them through antenatal care when they are just coming to book. The words I have put in are empowering women to make their own decisions, the joy, the love and the wonder of childbirth, protecting them through pregnancy and birth using my intuition and sensitivity and something deep and spiritual in me which often comes out at a home birth. In the centre of my collage I have the end result of a man, a partner and a baby and the joy on their face with the midwife. But to get to that you have to juggle all these balls that come into your life, mainly through work, be it time constraints, be it financial constraints, be it management, policies and procedures. It’s very hard to keep that normality in the centre of your mind when you are up against every day work really the stresses, the frustration, the job being scary and occasionally feeling a little out of your depth and unsupported and that’s what my picture represents. I’ve also got pictures of women with glasses off holding their faces and often you feel like that at the end of the day. And you know picture of doctors and managers and 9 times out of 10 you go home with those feelings but the one time out of 10 where you are at a home birth and everything’s gone fantastic this is what this job’s all about, normality of birth and the celebration of that I suppose. And that is very much in the centre and I see that as being the absolute outcome of all of this, the happy family. I suppose I just chose the
words that I liked, how I perceived birth really. There wasn’t too may negative words there though was there …though I was surprised by- impotent. I suppose that’s impotent in not being able to do anything about it, things that happen, I suppose.

Lucy: community

The picture is sunny, bright, cheerful. They are all bright and I like them all but that’s why I chose the yellow out of all of them, anyway. I have deliberately kind of offset it, if you like, in that nothing’s square in this world and sometimes we’re trying to put, or it feels like, we are trying to put things into boxes, a bit like a children’s shape sorter, if that makes sense, you know, circles into round holes, or pegs into square holes, whatever. As a community midwife, I have chosen pictures that I see are midwives support, or I assume are midwives, supporting families in their pregnancy, in their child, giving birth and afterwards. So I have chosen waterbirth settings which I feel are perhaps more home looking, whether they are actually homes or in units, I don’t know, but, midwives supporting women in their choices and what they are obviously doing, the support that they are obviously giving. Sometimes its communication and sometimes I think it’s just by being there, holding, supporting, encouraging. There’s one which I’ve used, as a midwife, which I folded in half because it shows the midwife, well the lady I am assuming is a midwife, obviously tired, stressed, holding her glasses with her diary in front of her, eyes closed, and I think sometimes that’s how we feel but we are very careful perhaps that we don’t show it to our clients at the time and maybe sometimes it’s just that what the client wants is pushing our boundaries and we’re, and maybe we are just over tired. And then at the bottom I chose somebody doing some documentation mainly because everything we do in practice also has to be underpinned by our documentation to demonstrate the whys and wherefores and what we did and why we did it and when we did it, as much as supporting the client, the documentation has to show good levels of care, demonstrates good practice. I also chose a more sort of traditional, delivery suite picture, not because of where it was, but it shows the staff communicating and I just feel that as a community midwife communication, or for any midwife, communication has to be key to everything and that’s kind of sort of in the middle. But, whether it’s your colleagues you are communicating with or your clients levels of communication need to be exemplary.

Some of the words, right. I think I’ve chosen things like establishing relationships, holistic and social, supportive, promoting self-esteem, self-belief, healthy
behaviours, women and family, art of normality, with woman, wonder, joy, protector, empathising, sensitive, encouraging, supporting choice, confidence building and responsibility, because I think as a community midwife you become part of the families, admittedly for quite a short period of time in the bigger picture of things, but getting to know women and encouraging them to have belief in themselves is very satisfying and promoting the normality I think those are all things that I endeavour to do for all my clients. It may be that some clients need more than others, but may be some people are already, you know, have their own self-belief, where some don't. It's maybe that some don't need you to be as supportive perhaps as others.

[Looking at the other pictures] I thought this was also very relevant but I felt that in theatre gear was a bit of a no, no for me definitely- that's the stress one with the stethoscope. I thought that looked very clinical for a baby bath and there are no family with it so that didn’t seem quite right. This I liked but then they the majority are in theatre greens and it made me feel that this was more a medicalised setting I suppose –practising suturing. But it's a skill that we all need and need to practice as well. The delivery suite coordinator definitely isn’t me (laughs) but I do have other time management skills so I used some of the smaller ones because I get more on the page.

The caesarean section was the other one that I thought whilst I support women ‘having’ to my mind that's the actually ‘doing’ of a caesarean. Working within the community I can count the number of times I’ve been to theatre probably in the last couple of years on one hand and so that’s not something I see necessarily as part of my role at the present. But I am sure that there are midwives that do see that as their role, just depends on where you come from. It’s like the blood pressure pictures I felt that one’s having a dynamap and one’s having it done manually but it’s definitely a hospital setting, medicalised, rather than routine antenatal care, if you like, that's how I felt anyway

Pamela-hospital:

To make this picture of the meaning of being a midwife I’ve kind of broken down the pictures and I’ve looked at what the physical aspects are of being a midwife, being with women, helping her through her labour, kind of touch, closeness, working with her family, being there in close up with everybody. I didn’t actually see them as a
home pictures; I just kind of thought of the environment, so it could have been in hospital or I, cause I’m a hospital midwife I was thinking of hospital. They didn’t strike me as being at home, I just maybe imprinted them in the unit I work. And then I’ve combined the other side of the coin so to speak, the demands of the job really. The picture is there of the midwife who is tired and pressured of, of working on the delivery suite and maybe with the board and the demands of juggling all that really. There is one having time with the woman who’s sitting there breast feeding her baby and the end result really.

The words I chose, I kind of divide them into two, like a kind of a venn diagram, you know those ball things when you were a child at school. As I’ve become a midwife longer and longer the basic principle of being with a woman, keeping her safe and being strong for her, being strong in the process of birth and believing in her and advocating in her labour, being an advocate for her and getting her the experience that she wants and the normality that hopefully she can achieve: combining that with the duties of a midwife, professional duties, the protecting duties, the being supportive, enabling and empowering and understanding and all those sorts of things. Yet in another aspect of the job is how scary it is, the conflict it is, the frustrations of it, the frustrations of lack of staff and you know, busy places, lack of support the whole way round. I work in the main unit and how the conflict of that and being responsible for so much; the responsibility of the job really. I have put ‘struggling against biomedicine’ because there is a battle ground [with doctors] and conversely there’s a conflict, there’s a struggle there

Mary Dix: hospital

I have put in the centre, that’s the ultimate goal of um Mum, dad baby, happy ending, obviously very happy with their experience with their midwife and all round I have just put... all the aspects of my job in what I see, because I am obviously a delivery suite person, the coordinator, the multiprofessional liaison with the doctors, and obviously we have got the high tech, stuff and the resuscitation of babies. But on the other side I’ve put the other part of my job is all the normality and um supporting women and being with women and down here obviously the teaching aspect ... I have put the responsibility there to pass on our knowledge and our skills to the next generation of midwives, Obviously how I feel the captions about being a midwife, being supportive, being with the woman, and the witness the power of birth, it doesn’t cease to amaze me the wonder of it ...the tired stressed midwife at the
bottom which is not unusual and you have to be dedicated and certainly in the um how it is at the minute with the busyness we have been you have to be dedicated to the cause I think to survive and the whole system is surviving on dedicated staff at the minute um so that’s my whole aspect.

I think I [deliberately] did it as two sides I think there are two aspects, coz some midwives possibly only see this bit, obviously community midwives do home deliveries so they are just dealing with the normality very much um in the home but as it is I do a bit of both really so I suppose there’s two sides to it and my coordinating days are certainly different from my caring for women days.

On my coordinating day I am obviously supervising midwives …I’m having to care for, or be responsible for all the women on delivery suite and to coordinate and to know what’s going on and to be supportive. But when I am not coordinating and I’ve got my patient, although I am still aware of my colleagues and be supportive if I need to I have got that confidence that I’ve got my woman and she needs me and I am in that room with her and I haven’t got to worry about anything else, somebody else is doing that.

I have the technology, I suppose yes I have put the hospital high risk aspects of my job I suppose with the coordinating ones side but also although it’s still hospital based and not community based I still what is portrayed as the normality on the other side even though it is in a big hospital setting. That’s how I see it, even though I don't work on the birth suite I always think of it as two, the high tech part of my job and also the normality as well.

I put being remembered because I think to be part of a birth and if it’s a nice one, I think people do remember you and I think that’s quite special. The stressed midwife at the bottom, why I’ve put that there, I just think um yeah it has been, it’s the climate we are in at the minute.

**Connie: hospital**

I split it into two colours. I’ve used purple for what feels normality and low risk midwifery to me … I think that’s maybe because it’s the colours that’s used on the birthing suite…and purple to me feels that calm side of midwifery. And then I’ve
used a slightly more clinical blue for more clinical pictures. The one on the left is the purple and I’ve got a pool birth and a midwife hugging the woman in labour and a midwife sitting on a bed with a woman with a baby and a midwife with a lady taking a history it looked like. Then on the blue side we’ve got the board and somebody rubbing their eyes who looks exhausted. A very happy family picture with a baby mum and dad and a midwife smiling. Then we’ve got caesarean section and suturing workshop.

I think on the left is what midwifery is all about to me and is about normality and being with women, spending that time and having the time. I think part of my reality of my job are the pictures on the right which are the more technical, being the coordinator, writing on the board, being at caesarean sections and teaching. Being very tired at times but still at the end of the day whether I’m doing low risk midwifery or high risk midwifery it’s still the family unit at the end and so for me I find it hard to separate the two even though I’ve been very separate now.

So I think that I do separate it out on the pictures but I probably do separate it in my mind but when I’m working I flip from one to the other very quickly which is why I’ve linked them. I’ve written the word calm because I am quite a calm person and it’s the one thing that will be said back to me which is oh you don’t flap and it doesn’t matter to me where I am or what I’m doing, I will just get on with it. So I think they can be linked and if you can link it you can make the patients more confident about it.

I think it’s very easy for that confidence to be whipped away when things don’t go to plan and that’s where on this side of the more technical thing I think you tend to be, my role is to be behind those people that perhaps you can see the confidence ebbing and that actually could boost it back up again to make them feel how they feel when they are doing what they do best at that moment which is normality. I think you need the normal to have the confidence built to deal with the deviations for normal.

I don’t think that more accountability isn’t necessarily on the technological side but that it’s underneath the picture of the family. I don’t think it’s necessarily just this side, I think that accountability is used in all of it. But the accountability has to be keeping in mind that that’s what you are ending up with and that’s what you are accountable for. The safe passage from conception to delivery....
I felt that they fell into two groups. I think that some of the words were quite sad. I think people had written things like stress and most frightening job in the world someone had written or scary, I think that’s very sad. And the pictures I think they fell into two halves really, normality and what we perceive as slightly more high tech and it think that probably sums up units I work in.

**Archie: hospital**

Archie: I mean the picture I have chosen here is because this lady is strapped to a blood pressure machine it’s all looking very medicalised. If that’s a midwife you wouldn’t know by the way that she’s dressed, because she looks very medicalised. It’s a nursing picture. You wouldn’t really even notice that the woman is pregnant. There is nothing relaxed or pregnant- orientated about that picture until you really look at her tummy so everything there, unless she’s looking at it probably got pre-eclampsia or some blood pressure problem, although they’re happy it doesn’t look like a general run-of-the-mill antenatal check. Everything’s technological here, so I find that very technological. The lady looks very professional, if that’s the midwife. She’s not relaxed, there’s not eye contact there, she’s touching but it doesn’t look like she’s thinking about the woman. I think she’s worrying more about the technology that she’s thinking about and the observation of that woman. The middle picture is, that’s me, on a daily basis on delivery suite. You are constantly looking at the board of women in labour and I have put accountability there because overall you are making sure that all the women are cared for. You have to allocate a midwife to each woman that’s there so that’s your main thing that each woman has care in labour and is hopefully achieving a one-to-one situation. The accountability comes to the woman because unfortunately you are tending to pull midwives out of that room to go and see another lady as well because there aren’t enough midwives to go round so accountability to the woman’s affected, but also there’s the midwife’s accountability to make sure safety is within those realms but safety as in a hospital setting so I don’t like that, because you are constantly looking at the board when you are in charge thinking about progress in labour. But just by having that board you are probably affecting normality because you are constantly making sure that midwives are on time with progress checks and you can be rushing them along a little bit as well if you need the room. This is all about rooms these lines isn’t it and

---

17 In most hospital maternity unit there is a wipe-on, wipe-off white board on which is written the women in the unit and their progress in labour
how busy the delivery suite which is in everybody’s thinking so that little board and
the busyness of delivery suite is affecting midwifery.
Frustration because the documentation today is three-fold what it used to be, and
the times that I could sit longer with a woman breastfeeding or even in the labour
room or at home and, you’re not turning your back on them, but you’re writing. You
should be hanging onto the woman. You have to write now don’t you, because
otherwise your documentation if it’s not up to scratch then things can go wrong with
that later on so that’s a constant worry for all midwives at the moment, and a huge
frustration I find. I’d rather not write anything really [laughs], till the end. Sometimes
conflict because I hugely remember kind of bullying really early in my midwifery
career because of older midwives that weren’t doing things that you feel should be
the way things are done, I don’t like the way she’ handling that baby’ but it reminded
me of a time when midwives would hurry you up and I’m actually very conscious of
that as a coordinator now because it’s very easy to push midwives along that ‘have
you ARM’d’ or whatever and it might not necessary. You have to be careful not to
take that away from newly qualified midwives who I feel are more in touch with
normality [laughs] than you are the higher up you go, and the conflict of course with
doctors because you are constantly arguing your case and you are always, always
arguing your side of you know whether that lady is in fact in a delayed labour or
whether it’s just natural and she’s in early labour, whatever. My biggest thing at the
moment is the number of repeat caesarean sections which is being looked at but
that’s a huge conflict that’s going to take a long time to sort out but its hugely
annoying at the moment. Midwives are taken away from the labour ward to go and
assist with a caesarean that could have been avoided. But we are setting up a
midwives group to try and go into clinic with the consultants so that they are not
offering them just because they are asked, to do a repeat caesarean again. This
[picture of caesarean] I find that quite sad really coz you can’t even see a baby and
you certainly can’t see a woman in amongst all of that and that is the way that we
are increasingly going. I do find that picture quite sad and medical. It could be
anything; it could be taking an appendix out really. And the scary job comes
because I don’t really find it that scary any more but the times that my heart is in my
mouth is when I see for example a breech caesarean and even just the way the
doctors handle the breech and having seen in the past midwives delivering a breech
which is quite a gentle process I think that was related just because it was in a
theatre setting so most breech, even vaginal deliveries, are in a theatre setting that’s
sad and scary because they are not handling them right. There is huge conflict there
because the midwife in charge you are watching an obstetrician who is supposed to
be the person who knows what they are doing there with breech deliveries and
though they don’t because they don’t do very many and they have happened to walk
on because it is now their job to deliver a breech, because that’s what they do, call
the registrar or whatever when it’s happening, and I find that sad and quite scary.
For someone like [midwife name] who does a beautiful breech delivery in a calm
atmosphere, so I find that quite scary actually. So that’s my down side to midwifery
and, yes that’s the frustrating side to midwifery.

Jennifer A: hospital

When I did the course I had only just gone back into delivery suite I think cause my
beliefs’ were firmly entrenched in the community; I was a community midwife. Even
though I went into the hospital quite a lot I was never coordinating delivery suite, or
had ultimate responsibility for delivery suite- so I’ve changed my role and a delivery
suite based midwife. I work three nights a week and I coordinate- so maybe two out
of three nights I coordinate the delivery suite and the other night then I will be left to
take a patient- client- see that’s different isn’t it? I call them clients before- and
basically the conflict really. One night you are expected to be this very, quite
autonomous, woman who knows everything about delivery suite, can support junior
doctors, can direct registrars to making the right decision, have to liaise with
consultants that maybe will refuse to come into the delivery suite and to suggest
maybe it’s important that they do. It’s a very high impact managerial role you liaise
with the supervisor of midwives, it’s your responsibility if the delivery suite becomes
too busy and if there is an incident that happens and you haven’t alerted a certain
number of staff or you have decided to close the unit then you are blamed- why did
you do this, why did you do that, why did you do the other. Then on the other night
you may be, as a senior midwife, there’s usually two senior midwives and you might
get allocated high priority case on the delivery suite so sometimes you don’t get to
see an awful lot of normal birth, you don’t get a chance to go down to the birth suite
very often and you will generally be given the most complicated lady on the ward
because you are the most senor midwife, which is appropriate. So unless there is
more than two senior midwives on as a senior midwife you see more complicated,
definitely more complicated stuff and a backup for the other midwife if she needs to
go into theatre. So normality is removed from the senior midwives on delivery suite I
feel. If you proceed to a normal birth that’s’ lovely, but you will be given the high
complex, high dependency, ladies first and so your chance to get hold of a lovely
multip coming in to have a nice straightforward normal birth is rare. So that’s bound to affect how you view birth.

So all these things [on the picture] I want to be remembered for and basically I want to be thought of as a nice kind person who is a caring midwife, who gives women choice and is able to support them in whatever they want to do, and you take great pleasure in supporting a lady to deliver and they give you a big hug after or they send you a little card which says something really nice on it which makes you feel, you know 22 years down the line, still makes you feel really good about yourself. This is the right side [of the picture], ‘the best job in the world’ but also on the other side it’s the scariest job in the world.-, when you are running delivery suite and you have to ensure what is going on in every room, and know your midwife and to know whether she is able to cope with that situation in the room. You can’t rely on a midwife coming out to YOU [her emphasis] to say I’m not happy with this- you have to know everything that’s going on in every room and if you don’t something happens then it’s the scariest job in the world. And this is the sort of job, you can come home, and it can make or break you; you can finish your night shift and have a fantastic few days off, because you have had a good time in work, or it can affect your home life significantly, when there’s something gone wrong or there has been an issue, because though I like to think the blame culture isn’t around, it is very alive and kicking

Which is why criticism is there and blame and gossip, and that makes you frustrated and extremely sad, extremely sad, and for your colleagues as well, when you see them and you know the gossip, if that’s too many women working together, but there is a sort of support mechanism but it’s [hesitates] woolly, shall we say. The support mechanism is just to find out a bit more information about what happened. And midwives are blamed if there is a problem. They should be able to control the consultants, doctors, midwives and the situation and sometimes it’s very difficult as things happen very, very quickly

**Lizzie: hospital**

I have done lots of sticking- you asked me to put together things that I thought were appropriate to midwifery at the moment or as I feel today. I put that it is professional because I think that is one of the most important things that it is a profession and in
the profession you have to be quite strong because you have a lot of responsibility. These pictures here are where there is a midwife who is really stressed out, I have put there that it is frustrating at times especially at the moment where I work the birth rate is forever it seems to be going up. We never seem to have a quiet shift so it can be frustrating when you don’t have enough staff or you have things you think are going in one direction seem to suddenly make a turn in another direction and you’re accountable for everything. It can be quite stressful. All the time we are protecting as a senior midwife you are protecting well protecting yourself but you have to protect the staff that you are working with and the women that are on the unit um and you have a duty of care and you also have a duty to your obligations as a professional working mother, working on the unit. It is, I think it is a vocation, you can’t do it if you don’t like it and there is some sort of calling there. I don’t think everyone can be a midwife. I mean there’s a mixture of people who are midwives, we are not all cast out of the same mould and everybody has different expertise but I think there are a lot of people who I know and I have a lot of friends who have trained as midwives but once they have done their training they have worked 6 months and they know it’s not for them and I think it’s something you either can do or you can’t so I think it’s the only way I can describe ‘calling’. It’s, you know, perhaps it’s a need as well. You have a need to do it in some ways. (laughter) But I do enjoy being a midwife. I can’t imagine doing anything else now. The constant learning I put down was sort of a group of midwives suturing. I think when you stop wanting to learn that’s possibly the time to give up I think you’ve got to all prepare to learn, adapt and be open to suggestion whatever you are doing. In midwifery can be quite as a profession as a practice as a job it really can be quite normal quite straightforward but it can be very technical. You can be divided between the doctors and normal practice and very often you find that doctors are wishing to jump in before you really need their assistance sometimes. It depends which doctors you are working with and the professional respect you have between the two. It does depend on the doctor but recently I had an experience with a doctor who came, he came from a very male-orientated culture. We had a lot of struggles with him for a year of the beginning of the year that he was with us in that he was trying to impact on what he believed. We had to take him aside at one point and almost retrain him with the interpretation of CTGs and the technical side of things and his attitude, and at the end of his year his comment to one of his colleagues he was handing over to was ‘listen to the midwives, they know what they are talking about’, which I think was actually very complementary from our point of view because he was a very experienced obstetrician, he was a very experienced doctor he had a lot of valuable experience
all round, in various parts of the country and abroad, but that was his comment in the end, as he was leaving which I thought was quite valuable, quite complementary and its interesting as the doctors get used to the team on delivery suite and the midwives they do take on board things that you will, it can be a two-way, a partnership, but it takes a while before that emerges. You’ve got to work as a team and you’ve got to know who you are working with especially being a senior midwife and sometimes coordinating the shift you also have to know people’s level of expertise so that you can step in should the need arise even if its above or beyond their experience you then know you have to get someone that’s more senior, especially if you are being the woman’s advocate.

The pictures here are supporting women and they are mainly home, they seem to be women who are at home. I mean the art of normal midwifery is being with the woman and supporting her supporting her choice believing in her perhaps correcting her if things aren’t going right but...to adapt to as much normality as possible, empowering her in the best way you can but respecting what she wants as well because there is a respect in all ways: there is respect of the medical profession cause their aiding your job, there is a respect of your other professionals that you are working with the other midwives.

I mean as a whole it’s, it’s a whole if you look at the whole perspective, the ante-natal support. You are just building on top of one thing to another the ante-natal, the intrapartum, the post-natal you have to have a good knowledge base and everything can be very normal and it can be very rewarding but at the same time things can go very pear-shaped and I think you learn from being reflective. You do make an impact. It’s amazing the number of women will remember, most women will remember their deliveries whether they are good or bad. If it’s good its positive but they will always remember the bad things as well. Most midwives will try and try and induce a calm environment like I put over there and being a witness to delivering a baby is quite an amazing thing even after 20 odd years and on the whole although you are working with the whole family you are basically working with the woman and supporting her towards the birth and believing in what she wants.
The method is clearly a valuable way of encouraging interviewees to talk as indicated (e.g. Gauntlett and Holzwarth 2006, Kaplan and Howes 2004, Taylor 2002).

Archie (H): *I love that midwife, she’s great, she’s lovely, that’s true midwifery and she’s so with that woman and supporting her and that woman must feel very loved and protected because she is right there with her, isn’t she, she’s not at the other end of the room writing her notes, and she has so got an understanding as well of what that woman’s going through and I feel the woman feels really safe there. Confident-again this midwife is very confident. That’s how you need to be to give the woman confidence enough to stay in her own home. It looks like she’s going into the hard part of labour if you like, its looks like the contractions are certainly picking up, she’s finding it uncomfortable now, but she’s right there with her and she’s talking her through it and she’s just getting her there, which is great.*

Lizzie (H): *The constant learning I put down was sort of a group of midwives suturing. I think when you stop wanting to learn that’s possibly the time to give up I think you’ve got to all prepare to learn, adapt and be open to suggestion whatever you are doing. In midwifery can be quite as a profession as a practice as a job it really can be quite normal quite straightforward but it can be very technical.*

The midwives also felt more comfortable in using his method: I record in my diary how the midwives ‘jump in’ to this activity quickly and with comfort:

*18th October 2007*

*She did not enjoy the last creative session due to needing more time so I wondered how she would react to doing the activity. I gave her the choice to opt out, but, no, she ‘jumped’ on the floor and did her picture...*
Lucy (C): *I thought this was a beneficial way to explore being a midwife because there were quite a lot of pictures that I related to I suppose that I can see myself in those situations and no doubt the pictures aren’t going to suit everybody all of the time.*

Connie (H): *I felt better [about doing this activity] this time. I think that it was just because it was not such a shock that I had to do something with paper…I felt more confident about this time, I felt I knew what I was doing and that’s like any task, that if you have done it before it’s not so frightening.*

These examples demonstrate that the use of photographs of midwifery practice and words enables the midwives to consider the issues around their practice in a visual way and helps them sort out their ideas, enabling stimulation of discussion. The pictures themselves are examined further in the following section.

**Examining the pictures**

Examination of the collages showed a difference between the midwives who worked in the community and those who worked in the hospital. The community based midwives generally chose to create the collages on one sheet and using fewer pictures than those from the hospital. The pictures they chose mostly focussed just on ‘normal’ care. In contrast the hospital midwives created quite ‘busy’ pictures. They all demarcate the collages into two sections, with ‘normal’ pictures on one side and the ‘science’ technological hospital based pictures on the other. This indicates that community based midwives are more aware of their role as focussed on the ‘normal’ side of pregnancy and birth while those in the hospital recognise there is a difference between the more medicalised role they are expected to have alongside the ‘normal’ focus. All except Sally Ann included a picture of a midwife displaying stress or anxiety; a reflection of pressure they are currently feeling in their roles. Some of the midwives added in words or pictures to enhance their collages. Jennifer also added a bow made of lace.

In the constraints of this study it is not possible to fully evaluate the pictures and the words used to describe them. However the use of the creative elements shows that different dimensions may be explored though their use.
8:5:4 The education session

As these midwives had been part of an education session where creative methods were used discussion included reference to the session itself.

Views of the session

The midwives generally found the session valuable and useful. Connie talked of the art session being a spiritual place.

Connie(H): I felt the teaching session was a time to be allowed to visit a spiritual place and look at what it feels like to be a midwife. It made me feel a reawakening of what brought me to into midwifery. It was an emotional, valuable experience… I feel midwives exploring meaning is a valuable exercise and it helps to banish some of the cynicism that creeps into delivery working!

Pamela found it valuable to her to explore meaning.

Pamela(H): I think that midwives exploring meaning is really important. For the profession to continue in a robust way we as midwives, we need to be aware of changing facets of the profession, identify our area of expertise and strength and hold fast to it.

Others indicated that exploring meaning in this way was relevant to them:

Mary D(H): I feel midwives exploring the meaning of being a midwife to be enlightening. The use of artistic methods was fun and revealing.

Kerry(C): My experience…was extremely thought provoking, calming…It makes me reflect on my own practice, was inspiring …I feel every midwife should revisit their career and focus where they are at what point…Using artistic methods to explore was extremely therapeutic, and felt privileged to be given the time and space for this… I just enjoyed doing something like that coz you are given very little time…to do something like that and it’s against all the norms of learning and reading.
and researching… it was a good piece of communication in chatting amongst colleagues and finding out how other people felt.

Archie(H): The teaching session was a good exploration of spiritual midwifery. It was nice to have time to reflect on yourself and your own practice. I feel it is excellent, very important for midwives to explore the meaning of being a midwife.

Mary talks of feeling she needed more time to do the art.

MaryD (H): I remember not being very good at it…and I am actually quite artistic and creative. But in that very short space of time I absolutely had no idea what to do… and I can remember feeling under pressure because other people were cutting and doing and thinking and I'm thinking I can't be that. If you'd given me an hour to think about it I possibly would have come up with something more creative…

The purpose of the speed of the required response was to ensure that those with art ‘interests; would not have time to ‘think’ cognitively. Others were challenged by the use of art in this way.

Connie(H): I thought using artistic methods was great fun, though initially horror at having to express using art, but I really enjoyed it. …by the end of it I think it was quite interesting to see how everybody else perceived and I actually think everybody did kind of perceive it in a very similar way from what they produced…I wouldn’t have said that was the most enjoyable thing I’ve done but I don’t think it was as bad as I thought it was going to be. I am not really a very creative person either. I say that but I’m out there sewing now, making things….

Lucy(C): There was a sense of anticipation-what can I learn, benefit from? Do I have any artistry?… I am excited about using artistic methods to explore meaning, because it was a new experience I feel I will remember and benefit for the future.

Jennifer-A (H): Making cards and pictures doesn't float my boat and I sometimes don't understand why…but that's me and not a criticism of
you. I suppose I feel a bit daft because I am not creative really or am I?...maybe I don’t have enough time to explore myself.’

Sally Ann(C): I do not consider myself as artistic so find it difficult to let my imagination flow or interpret on paper what I would like to show. Initially [about the art of midwifery session] I thought ‘Oh God what is this rubbish?’ but once the thought process started I realised it was actually very thought provoking. I wasn’t very comfortable I must admit, because I have never, ever been a very arty sort of person. But I actually got more out of it than I realised.

Despite not feeling comfortable about participating with the use of art initially these midwives found it beneficial to help them reflect on their practice.

**Impact of the session**

All the midwives felt the session was relevant and it appeared to have an effect on their ability to reflect on their practice:

Archie(H): The interesting thing was how a hush came over the room once everyone got going. And in actual fact it was interesting to pull from inside you your feelings about it because you don’t have time to stop and think of yourself as a midwife do you really? You kind of run through every day and then get home and sleep because you are so knackered and you don’t actually stop and think about your practice, well you do as far as next time I won’t do that or the clinical … bits that you have to reflect on all the time. Because if anything does go wrong you certainly do look at yourself as a midwife but I think to look in your inner self to see what kind of midwife you are was actually quite an opening experience.

Pamela(H): I found the experience… thought provoking in a way I hadn’t reflected on before. It made me think deep within myself what my fears are in midwifery, the respect I have for the job; how on one level how much my job means to me,
Sally Ann (C): I think being made to take time and actually think about what midwifery means to you and then to interpret it in a physical way… was really beneficial,… I think you do when you go into midwifery and you do in your training, you are made to think about it, but when you actually move away from that setting and you are doing the job day in day out you don’t really stop to think what midwifery means to you and that’s what I found the session useful for me. I actually had to stop, sit down and think why am I a midwife and what does it mean to me and in the way things are in the NHS and midwifery at the moment I think we need to do that more often perhaps…. we get involved in the politics of things and we get away from why we are really doing the job itself. So that’s where I found it useful. I think it just sort of clarified it all, I think to stop and think why did I come into the job in the first place, what do I get out of the job now that keeps me in the job because there are times when you think I just can’t do this anymore, but it was good to actually sit down and think…that’s why I am here, and that’s why I want to carry on, because that’s what I want.

For Sally-Ann the need to ‘stop and think’ is obviously significant to her. Kerry states how the session made a difference to how she approaches her practice in the community.

Kerry (C): I think it has [made me different in my practice] in that because of litigation you just tend to be so by the book in dot the l’s and cross the t’s and I know you do have to a degree be like that but probably in antenatal teaching I suppose you know that is the time to really hit people and to talk about what they want in their experiences and I suppose if somebody comes to you and says something that doesn’t quite fit in with the norm in the consultant-led care in the hospital I would probably listen to them more and take on what they are saying in their experience and you might not agree with what they are saying but you certainly listening more and trying to understand how they feel: especially people wanting home births who aren’t quite the normal midwifery-led care.

Others also experienced an impact on their consideration of practice situations:
Lucy (C): perhaps doing this has made me think far more about the promotion of normality… it’s just made me feel more powerful and stronger in the let’s try and find some normality somewhere … perhaps it was just I was getting old and jaded, I don’t know (laughs), combination perhaps. Perhaps what it’s done is that it’s made me think about the art, the intuition, and the module itself on promoting normality has helped me to take stock and kind of put me back to where I was, still with the experience but with that inner belief that actually women can do it and all I need to do is convince them now (laughs) - try my hardest, some battles will never be won.

Archie (H): I definitely learnt something, yes. I found it quite emotional actually, but not really. It was a mixture of things. It was quite nice to see how you look at it again. Because you don’t really do that after you are a student, get lost in the business and everything around you that you don’t really look at yourself as a practitioner and not that deeply, you do from a practical point of view or maybe from your documentation point of view but not about your practice in yourself which was quite interesting… Possibly it changed my practice because what it did enable was time to reflect and before I went down to [name] ward I ….. I did work on the birth suite more interestingly. It's so difficult because as a co-ordinator. It becomes more difficult to move around. I did work there anyway but I pushed myself more afterwards. It’s nice to get back to basics.

Lizzie (H): It was reflective. It made you think. It was interesting that even though we were given the same agenda that everybody came up with something different. And that we were all experienced midwives and we were all the same era of training and that’s why I think it just shows the art of midwifery or skills of midwifery or midwifery in general is so big… I think …it’s so different whichever way you look at it and you are always learning from people. I think that it’s quite refreshing in the art of midwifery in that it makes you think about what you do… I’ve gone back… I have looked at things from a different angle. …I think it made me reflect on what I’m doing and why we do things and explaining things to students.
However Jennifer and Connie did not feel the session gave them any new learning.

Jennifer-A (H): I don’t think that my practice has changed [because of the session] but it’s refocused…you think, I was reading lots of articles on intuition.

Connie (H): I don’t think I [learnt anything] really if I’m honest. I think I already knew, my own piece of art, I already knew that’s how I felt. I don’t know that I needed that medium to express myself. But that may have been me and other people may find that medium very useful. It’s not my medium…so I don’t think I did learn anything particularly different about myself. I just think I learnt something about some of my colleagues who I worked with so that was quite interesting.

In general evaluation of the session demonstrates that the midwives valued the time and space to sit and reflect on the meaning of their role and the use of art facilitated opportunity of deeper reflection which gave them some valuable insight into their practice. The group session also gave opportunity to share together and the art was seen as a good trigger to stimulate discussion to reflect on wider issues of their practice. Not all the midwives were happy with this method initially; however they were able to see value afterwards. The session therefore had an impact on them personally and also within the context of where they were working.

This section of the thesis illustrates some different ways in which the material of this bricolage could be explored and how the different elements would produce a multidimensional picture of the whole. The following section will explore some of the findings elicited.