

Section 2 The roots of my enquiry

I stop for awhile and look back to what has brought me to this place on this journey...

In line with an heuristic form of inquiry where

The self of the researcher is present throughout the process (Moustakas 1990:9)

and organic inquiry where

the principal researcher's experiences are also the seed of the research. It is the researchers' interest, passion, or deep questioning that is at least the touchstone of the research study, if not an integral aspect of it. (Curry and Wells 2006:34)

I begin this journey by examining my personal history and beliefs that have inspired me to explore the questions that guide this study.

2:1 Personal history

When I commenced the EdD programme I had been a qualified midwife for over twenty years, a nurse before that, and in education part time for six years. In addition I shared my education role with editing a midwifery journal, had authored a book and chapters in others. Outside my work life, but also intrinsically part of it, I am a wife, a mother to five daughters and daughter of aging parents. Starting on an extended period of study would therefore be a professional and personal challenge.

In looking back I can see that many of my values were shaped in my childhood, where I grew up in a loving family. I was a creative child and was always making something, often very quickly. In my teenage years my creativity was explored through making music, writing and sewing clothes. I was influenced by attending a Christian church from an early age and developed a strong belief that there is a God or Ultimate Being and that human beings have a 'spiritual' nature. I 'knew' I wanted to be a nurse from an early age and always considered this as a 'vocation'. This shaped my choices during my schooling and also meant that when I 'failed' my 'A' levels it didn't particularly concern me as my career path was still laid out.

My nurse training taught me many of the practical tasks involved in nursing care, but my personal philosophy that recognises each individual's value and worth underpinned my attitude in that caring. I can see that these were the roots to my understanding of a holistic (whole person) approach to care. I was quickly introduced to suffering and was privileged to be in close proximity to many people as they died or faced the prospect of death. This increased my perception of each person having a spiritual nature, as I felt the spirit of the person leave their physical body behind. But I was most inspired by having opportunity to see the start of new life in the maternity department. I was challenged there that the issues of life and death at that moment were very close, especially when a woman died in front of me during a caesarean section. Working in central London I was aware that women from many cultural and religious backgrounds asked for recognition and facilitation of their rituals to celebrate the life of a new child. This aspect of the holistic approach appeared to be missing from birth for women from my own culture and was excluded by some midwifery colleagues. This short placement led me to apply to train to be a midwife soon after I had qualified.

It was as a student midwife that I began to question the 'whole person' approach to care more deeply, considering the spiritual nature of birth and the role of the midwife in this process. I read extensively about midwifery and discovered books such as 'Spiritual midwifery' (Gaskin 1977, 2002). This described a 'hippy' culture developed outside the American medicalised system in order to enable women to have births in their own homes. The women's stories identify their intense experience of birth, facilitated by other women from the community. I was also inspired by 'Motherhood and God' (Hebblethwaite 1984) written by a Catholic woman describing the process of becoming a mother and her subsequent relationship with her God. At the same time midwife Caroline Flint was challenging the medicalised approaches of midwives in the UK through her writing, including 'Sensitive Midwifery' (Flint 1986). This literature increased my questioning about the way women were treated during birth in the unit where I was based and how this could be translated in my own approach to care.

As an observer in a technologically entrenched, medically controlled environment in the early 1980s (Campbell and MacFarlane 1994, Wagner 1994) it appeared to me that for women, and often their partners, there was a transformation that took place at that moment of birth. They consistently noted the miraculous nature of the experience. The most significant times to me as a student were those I

spent at births that took place in a woman's home, which were regarded as 'normal'. For me this appeared to be the best environment to have a baby, where the woman and her family could 'be themselves' and where we, as 'professionals' were the guests. Here I began to recognise more deeply the concepts of 'women-centred' holistic care. This was in stark contrast to the fragmented care in the clinical environment of the hospital unit where I did most of my training.

At the same time as a student I observed midwives. There were those who appeared to fulfil the requirements of a 'job', acting in a manner that was task-orientated and controlled by protocols. In contrast were others who still performed the same tasks, but somehow also carried an aura with them that appeared to promote healing and calm, despite it being a busy environment. In nursing terms this has been identified as those with 'glassy eyes' or 'clear eyes', illustrating the concept of 'presence' (Wright 2001). I recognised these were the midwives I wanted to be like. It was later that I established that the majority of these midwives had a particular spiritual faith or belief and began to question if there was a link between caring attitudes, values and personal beliefs. I was not able to follow this up as I became entrenched in the political changes taking place in the profession, and my working environment was not conducive to research at that time.

2:2 Midwifery professionalism - a short history

At the time of my training midwifery was only just beginning to develop an evidence base. Evidence in the form of academically recognised research did not start to take place until the 1970s and midwifery journals separate from nursing or medicine were not published in the UK until the 1980s. This was despite the historical knowledge that has been handed down from woman to woman throughout generations of midwifery practice. Little of this was recorded officially, though doctors from ancient times such as Soranus (Dunn 1995), described issues around birth from a male perspective. To this day much of midwifery practice remains unresearched, and would have difficulty being researched, due to ethical constraints, as well as women's views and choices around birth.

A significant proportion of the 'evidence' for midwifery practice until recent years has been based on medically based research undertaken mainly by men, which some feminist literature states should be challenged as midwifery remains a female dominated role, as is pregnancy and childbirth (Davis-Floyd and Cheyney 2009, Oakley 2005, Belenky et al 1997, Gilligan 1993). The assertion that 'midwifery

knowledge' is different to that in the medicalised technological paradigm is beginning to be debated (e.g. Davies 2010, Downe 2010, Parratt 2008, Hunter 2007, Downe and McCourt 2004, Wickham 2004a, Kelly 1997). Medical care continues to be viewed as more authoritative and expert, despite the research that has been carried out (McHugh 2004). The culture of midwifery globally has not been regarded as having the same status as more traditional male-dominated professions (Fook et al 2000:2). The basis of being generally a trained profession rather than educated, poorly defined by research and mostly female has served to give this impression in sociological terms.

It is suggested that midwives have subsequently tried to emulate other professions despite the feminist notion of 'profession' being a patriarchal concept in that the membership is the 'social' elite with enduring access to power (Bates 2004). This concept has been described by Michael Eraut (1994:5) as 'professionalization', where occupations seek to gain status and privilege. Relationships between midwives and other professional groups, particularly medicine, have been a challenge (Downe et al 2010, Hastie and Fahy 2010, Pinki et al 2007) continuing in the UK with current discussion about who is the best profession to control the maternity services (Warwick 2011). Within midwifery in the developed world midwives may have sought to raise their status by moving toward technological and scientific paradigms to compete with other professions instead of valuing the holistic knowledge and practices that is grounded in the social lives of the women served.

2:3 Midwifery education - a short history

When I first qualified as a midwife the first midwifery research had only just been printed (Romney 1980). The theory of my midwifery training was therefore based on learning by rote and copying what others did without really questioning. My prime text book was factually written and contained no research evidence or references throughout (Bailey 1976). My training was eighteen months in length: it had just changed as the year before students were qualifying after a year. As with all courses at that time it was based in a training school in a hospital. There were twelve in a cohort (this is in comparison to the cohort of seventy students who have started on our programme this year). Students were expected to wear uniforms in class as we could be summoned to the ward areas to view an unusual placenta or to participate in ward teaching sessions, with a woman and her baby. Our training was therefore rooted in the practice area.

In addition, consultant obstetricians were seen to be 'in charge' and were involved in lecturing us. At the time midwifery had moved away from its community roots into hospitals since the publication of the Short report (Social services committee 1980). Despite the fact that women's groups had been calling for change since the 1970s (Kitzinger 2005), the medical profession had power in the hospital maternity services (Cahill 2001, Donnison 1988). This was something against which midwives and birth supporters were consistently battling (Wilkins 2010:87-88, Bates 2004). Key government reports, the Winterton report (House of Commons Health Committee 1992), and *Changing Childbirth* (DH 1993) gave opportunity to provide a service that would be 'woman-centred' and give women more 'choice, continuity and control'. Midwives were challenged to make changes and I became active in this cause.

In tandem, changes were taking place in midwifery education in the UK. It was in the 1990s onwards that the education of student midwives moved into higher education institutions (HEIs) following the introduction of three year diploma and degree pre-registration programmes. In 1986 the Association of Radical Midwives produced '*A Vision for the maternity services*' (ARM 1986). This included a recommendation that midwives should not require a nursing qualification, as in the Netherlands, where midwives appear to practice autonomously, and Derby, where direct entry training had been available for some time. In 1989 the Department of Health provided the necessary funds to develop such courses (Kent et al 1994). This had come from moves by the then professional body, the United Kingdom Central Council (UKCC), to develop a generic programme for nurses called Project 2000 and to ensure students were counted as supernumerary learners instead of as part of the paid workforce. Though midwives successfully fought against becoming part of the Project 2000 framework, some courses became subsumed in nursing schools and involved shared learning and nursing placements according to financial or political need (Kent 1995).

The move into HEIs brought many significant changes to the education of midwives but also increasing challenges for those who educated them. However, significantly, there is little academic literature exploring these developments. Politically charged papers expressing concern were published (Alexander 1994, Hall 1994, Cronk 1992, Flint 1990), following on from a prophetic speech by the Royal College of Midwives president at the time, Margaret Brain in 1989, who stated:

If we lose control of our education we lose control of our profession (Flint 1990).

It is probable that educators at that time did not have the resources to enter into academic debate, as they were concerned about:

- moving physically from clinical areas and losing relationships with clinical midwives,
- moving into larger institutions with their own cultures and management structures,
- how they would maintain clinical credibility, with the student, their clinical colleagues and themselves,
- changes in management of midwife teachers, which was frequently devolved to others, such as larger nursing schools, despite the Approved Midwife status in statute,
- changes in the financial structure,
- increases in student populations that were now introduced once or twice a year,
- expectations to create new programmes that had to comply with university regulations, often creating a modular system rather than a programme that 'flowed' in relation to student need,
- discussions and conflict over whether midwifery should be included in the foundation programmes for the new Project 2000 courses,
- losing their jobs as some universities insisted there were too many educators. Training of midwife teachers was reduced,
- facing expectations of a 'research' culture within HEI's with many needing to gain degree status in order to remain in post,
- students no longer being based in one hospital but placed in any number of placement settings .

(Hall 1994)

It is therefore not surprising that midwife educators were not writing much about their experiences at the time of these changes. Commissioned reports on the development of the programmes (Fraser et al 1997, Kent et al 1994) were completed after the move had taken place. The research indicated that student midwives required more input into the skills of complicated situations (Fraser et al 1997) and it was recommended to redress the balance in education programmes. However recent consultation with the profession led to guidance for an increased focus on the normal aspects of childbirth in pre-registration programmes (Midwifery 2020 Education & Career Progression Workstream 2010, NMC 2009) with situations arising where workforce development gatekeepers are requesting modules on this normality for qualified midwives as this appears to be a perceived lack in their training. Moving the focus of programmes in the 1990s into complicated areas may have altered the balance of midwifery training too much. A questionnaire study was carried out, discussing the implications of these changes for educators, although it did not separate out those of nursing and midwifery (Barton 1998). This study demonstrated the stress these nursing and midwifery teachers had been experiencing relating to role conflict in the alteration of their working practices. Midwife lecturers have perhaps been so busy coping with the impact of change that they have had little opportunity to think about what it has meant.

Moving into HEI has meant that midwifery educators took on the roles of university educators, following the frameworks of planning, and styles and methods of teaching already utilised by other faculties. There were also expectations for them to achieve degree status to match the levels of the students they were to teach. The sudden need to adjust to much larger cohorts of students meant that they had to adapt teaching styles according to the resources available. It is not proven whether these methods actually are the best for creating midwives who are able to cope with midwifery practice in the 21st century (Anderson and Davies 2004). Thomas and Cooke (1999) wrote of the use of problem based methods of teaching but until recently there has been a minimal knowledge base of practical teaching methods for midwifery in the UK (eg Blake 2007, Davies and Wickham 2007, Mitchell and Hall 2007, Hunter and Hunter 2006, Rennie and Main 2006, Fisher and Moore 2005, Brunt 2003, McNiven et al 2002). In tandem with the apparent blind acceptance of medical technological practices in clinical midwifery it appears there has also been an acceptance of educational processes for midwifery taken from higher education.

Currently students are expected to complete a list of competencies as part of their programme (NMC 2009). Competency-based outcome measures are recommended worldwide (Department of Human Resources for Health, World Health Organization 2009). Such an approach demonstrates divisiveness and fragmentation in opposition to holism. It is suggested that midwifery education has subscribed to a patriarchal archetype adopting a rationalistic, scientific, reductionist approach to the management of pregnancy and childbirth that has also allowed compartmentalism of subjects (Davies 2004:144). If this is the case then there is an argument for investigating how the students are taught as well as the effects of the training programmes. The final report of the previous Prime Minister's commission on the future of nursing and midwifery (2010:3) proposes:

that nurses and midwives restate their commitment to the public and service users in a pledge to deliver high quality, compassionate care...Truly compassionate care is skilled, competent, value-based care that respects individual dignity.

This indicates a need to instill these qualities more effectively in students. A study about what competencies student midwives require shows that at the point of professional registration midwives should be safe in practice, but they also need to be effective communicators and have 'appropriate attitude' (Butler et al 2008). This latter aspect may be the most difficult to enable through traditional university teaching methods. However, Steiner (2002:101) suggests that 'right attitudes' can be enhanced by increasing our creativity. His implication is that creativity encourages self-growth and consequently a desire for wholeness and good. Though we cannot teach 'right attitudes' there is potential that the judicious use of exploring more creative methods may encourage the development of positive attitudes. It is significant to me that Bass (2007) identified that there is a link between midwife teachers being creative and having a holistic philosophy to midwifery practice. With this philosophic approach as an educator I consider the students as 'whole people' who require education in a 'holistic' way that will enable them to effectively care for women and their families.

The participants of this study have all been midwives during this time of professional and educational change. During discussions they made comments about current educational courses and highlighted concern about 'fragmentation' of student training and perceived loss of contact with midwifery education in HEI's. Despite over fifteen years having passed since the changes in structure to education, these midwives have not been convinced by the benefits. In addition they

have chosen at this time to be part of a post-qualifying module that focuses on the normality of childbirth:

Lucy (community-based midwife)(C): *I chose to do this module because of the need to reduce the caesarean section rate and improve women's belief in themselves.*

Lizzie (hospital-based midwife)(H): *The midwife is trained for normality and I chose to do this module as I need to refocus.*

The comments they made clearly identified a need to revisit basic past beliefs and values. Part of this study will consider the use of creative methods to enable midwives to explore their professional role.

2:4 Back to the journey before the journey

It was during this backdrop of evolving professional and educational changes that I was still practising as a midwife, but had also made an active decision to become a teacher of midwives. However, as I began the process of application and self-development the goal posts were constantly changing. The move into HE described above meant fewer midwife teachers were required and funding for training was reduced. It took nine years before I was able to become a recognised teacher of midwifery. Over that time we had moved three times to different areas of the UK and I had given birth to five daughters. My career choices had thus been influenced by my family circumstances (Robinson 1993).

The process of 'becoming' a mother informed further the knowledge I had of the holistic and spiritual nature of birth. I was challenged by the relationship with the unborn baby inside me and how this was already a 'person'. I questioned whether this unborn has a spiritual nature, and subsequently wrote about these issues (Hall 2006). Through being present at both birth and death, I recognise their closeness, the transformation that takes place of beginning or ending, transcending from one world into another. My own experience of birth felt at times like being on a precipice between worlds. The power of this experience was overwhelming and I was aware of lack of control of these forces on one level, yet I had no fear. Reflection on this demonstrated to me how much 'control' is taken by midwives at birth to try to 'control' an event that is meant to be uncontrollable. The process described of giving birth and subsequent motherhood changed my midwifery knowledge. Despite recognising that women and men who do not have children are able to be midwives

(Bewley 2010, Cooke 2010), I question how much the profound change of giving birth has on attitudes in practice.

I followed up the knowledge I gained of the holistic notion of birth during motherhood in the thesis of my Masters degree. Despite the influence of Ina May Gaskin's (1977, 2002) seminal work around spirituality, no academic follow-up of her assertions had taken place. Midwives had appeared to be concentrating on researching the physical practices used. Completion of the thesis demonstrated the paucity of evidence around the spiritual aspect of holistic midwifery and utilised the literature available relating to nursing and women to formulate a theory about midwifery care.

Current standards for pre-registration midwifery courses now contain requirement students show a holistic approach by demonstrating competence in:

knowledge of psychological, social, emotional and spiritual factors that may positively or adversely influence normal physiology, and be competent in applying this in practice (NMC 2009:6).

However there remains limited evidence to support which spiritual factors do influence normal physiology or evidence that midwives are already carrying this out in practice. In addition the students are required to participate:

in working in partnership with women in a way that is sensitive to age, culture, religion, spiritual beliefs, disability, gender and sexual orientation (NMC 2009:37)

This further implies an expectation for considering a whole person approach to care. My EdD thesis uses this holistic approach toward the participants which will be explored further.

Writing this historical and autobiographical background provides a personal context to the journey I am now on as a researcher. The story has led me to question:

- If midwifery has lost sight of its roots in the art of midwifery and has become too entrenched in the medically controlled, political environment of NHS trusts,
- whether education of student midwives has had anything to do with this and if the way we enable the students to learn could help improve the situation;

- if we are truly providing whole person 'holistic' care if we are not taking any notice of the spiritual needs of the women and babies in our care.

2:5 The ontological basis of the study: holistic principles, spirituality and creative art

The personal and professional history written above is underpinned by ontological views. I recognise my personal beliefs impact on how I view midwifery, how I approach education and now this study. It will be a challenge to 'bracket' or suspend (Holloway 2005:47, Crotty 1996) my experiences and I choose instead to acknowledge, indeed embrace, my beliefs on this journey and explore them alongside those of the participants. I am aware having written the above personal narrative that the words 'spiritual' and 'holistic' have different meanings to different people. I have identified from the literature other people's meanings but recognise my understandings need to be expressed in order to make clear my beliefs. It is therefore appropriate to be explicit what these terms mean to me.

2:5:1 Holism

My ontological perspective values the individuality of each person as central to caring. I believe that we are made up of physical, psychological, emotional, spiritual selves that interact with each other and that the health and well-being of these 'parts' are interlinked (Greenstreet 2006, Swinton 2001, Price et al 1995). Such a philosophy of a 'soul' as separate but part of the body was espoused by Socrates and Plato (Karasmanis 2006), with a connection between the health of the body and soul. The roots of the definitions of soul and spirit are different but often they are used interchangeably. The word spirit has a Latin root of *spiritus*, in Hebrew it is *ruach* and in Greek *pneuma*, which has the meaning of breath (Robinson et al 2003:21) or life force (McSherry 2000:25). The root of soul is also Greek, *psyche* (Cobb and Robshaw 1998:42-44). Further differentiation has associated the soul to being related to depth, self-consciousness and wholeness, while spirit is more an outward expression, related to height, God-consciousness and holiness (Cobb and Robshaw 1998:44). The soul is regarded to be part of a person that does not exist without the person and that the person does not exist without the soul (Willard 1998). In this context the spirit is the breath that brings life to the soul, the person. I view that the definition of 'spirit' and 'soul' are as one, which is:

the sphere of our being that is whole and complete and wherein we are most authentically our Self (Burkhardt and Nagai-Jacobson 2002:10).

This describes holistic interconnectedness and interaction of the spirit to the physical and the emotional aspects of a person, and externally to the social world. Contemporary expressions of spirituality refer to the 'spirit' as the essential essence of the person (McSherry 2000:25, Robinson *et al* 2003:20) and humanistic interpretations avoid terminology such as the 'soul' which convey specific religious positions on life and death. I am influenced by Long's (1997:507) statement:

...to be spiritual means...to become fully human.

The statement 'your spirit is what makes you you' gives a working definition to my current thoughts.

I also believe that we are social beings who are part of a social world (Cawley 1997). This means that we are influenced by personal history, culture, values, beliefs, upbringing, understandings and the social world to which we belong. I am influenced by my personal experience as a woman, wife, mother as well as midwife, educator and now researcher. In addition I recognise that what I believe affects how I approach all these roles.

'Holistic' care is significantly easier when a relationship has been developed. A recent discussion defines midwifery care as a tapestry, with the 'visible' threads as the more technological aspects of practice, with relationships as the hidden 'weft' threads (Hunter *et al* 2008). The authors' view relationships as important to provide strength and to keep midwifery together but that they have become invisible Kirkham (2010:268) also writes that the partnership relationship with women gives midwives:

Power to improve the health and well-being of families and communities.

Being a midwife to me has meaning within the role of being 'with woman', of building up key relationships of trust, which I believe are a significant part of a midwife's 'art'. If the role is meaningful to me as an 'art' as well as a science then what are the meanings for other midwives? In addition a midwife needs to provide safe, appropriate physical care, and recognise and address a person's psychological and emotional needs. This indicates that a holistic approach to care is relevant to midwives.

2:5:2 Spirituality

Of the elements of holistic care mentioned, spirituality is perhaps the least understood or researched, particularly in midwifery. In the past ten years there appears to have been a shift in acceptance of thinking about more existential aspects of life leading to a rapid increase in the amount of literature relating to spiritual issues, both in academic literature or in popular media.

In health care a perceived barrier to recognising spiritual needs of clients has been through belief that spirituality always equates with religious expression (Edassery and Kuttierth 1998, Cawley 1997, Burnard 1988). However a faith structure is also acknowledged as being a factor for positive health (Koenig et al 2001) and psychological wellbeing (Laurencelle et al 2002) which is relevant for caring for women but also for the wellbeing of the individual carer. From my personal understanding that the spirit is the essence of the self, I believe that all persons have a spirit, whether they choose to express this using a religious paradigm or not. Stoll (1989) has suggested that every person looks for something or someone on which to focus worship and this could be a personal God, another person or an object. For me the transcendent relationship is with God as 'here and now' (Lauver 2000:79) while for others it could be a higher being or ultimate power or finding ultimate meaning in situations or behaviours. The 'immanence' or presence of God described in relation to women's' spirituality (Lauver 2000:79) suggests this aspect may be a particular facet and one with which I identify.

In a previous study definitions of spirituality and spiritual care from the health care research literature were established (Hall 2001). I identified that they included some common elements with the most consistent being 'searching for meaning and purpose' and the aspects of connection in relationships [Appendix 1]. In addition I identified that some researchers suggest that gender may have an affect on the way personal spirituality is expressed [Appendix 1]. Though there is relevance here in relation to midwifery I have concerns about a division into feminine and masculine in relation to spirituality. To label the characteristics of one's spiritual nature according to gender thus denies the individual expression and nature of the person. However I recognise particular elements frequently defined as 'feminine' are significant to my personal expression of spirituality.

Waugh (1992) suggested there are vertical and horizontal dimensions to spirituality. The vertical dimension is viewed as the relationship with God, either in or out of religion or the personal value system on which life is focused. The horizontal dimension is presented as how the person reflects and reacts to the transcendent relationship or level of self-actualisation through their way of living and their relationships with themselves, other people and their environment (Waugh 1992). These two dimensions thus constitute a person's spirituality: how they express spirituality on a personal level and how this is then transferred to living within the world around. Personally I am influenced by this philosophy of 'Up-in-out' spirituality, which recognises interconnectedness of an internal relationship with God and expression of this within the social world. I recognise my personal transcendent relationship will have an effect on how I am able to serve others, to love or care.

Connecting relationships are considered an aspect of feminine spirituality (Burkhardt 1994), across past, present and future. These relationships may demonstrate spirituality through emotional responses experienced and through love, caring and giving. The closeness of spirituality to emotion is compared by Vaughan (2002:17) indicating both have 'varying degrees of depths and expression'. They may be:

conscious or unconscious, developed or undeveloped, healthy or pathological, naïve or sophisticated, beneficial or dangerously distorted.

Emotional responses may thus be experienced through memories triggered by a spiritual response in a place or through events. An example is shown from my research diary in Appendix 2. However I consider it is the person and the event that gives the spirit of the place and not the place itself. It may also be experienced through present relationships and the outworking of those as well as understanding the connections that will take place in the future.

The physical, emotional and social aspects of the midwifery role have been researched however there is currently no research specific to UK midwifery practice on spiritual issues, though a phenomenological study relating to nurse-midwives knowledge of spirituality in Hawaii has been completed (Linhares 2007) and on women's spiritual sense of self in pregnancy (Parratt 2006).with a further PhD study commenced in Malta. Recently Jesse et al (2007) examined women's views of the effect of spirituality on their pregnancy and identified need for midwives to recognise how spirituality is an important resource for some women. A further qualitative Australian study shows that women have a wide variety of spiritual experiences and

meanings related to pregnancy (Carver and Ward 2007). For some women, therefore, spirituality is relevant to pregnancy and childbirth and needs greater exploration.

In addition I also question the spiritual nature of midwifery with the link through caring and giving and entering into connecting relationships with the woman. Is this something that is intrinsic within the skills of midwifery or something that can be taught? If we understand that the expression of spirituality is a choice, that we can choose not to respond or acknowledge the spirit, then this also is something that is not to be forced on others. Ian Delinger (2010: 417) suggests spiritual care requires just two things:

- First, be open to them as human beings. Every patient is more than just their ailment. Be open to explore the 'other' or the metaphysical.
- Second, understand your own spirituality, what you do and do not believe, in order to be open to discussing various beliefs and concepts.

This is significant when attempting to facilitate learning of holistic approaches. From this statement spiritual care requires recognition of the individuality of the person being cared for alongside that of the carer. Facilitation of learning should include introduction of spiritual concepts and in addition aim to help the learner develop understanding of their personal beliefs..

2:5:3 Creativity

In addition to the above I see the spiritual in being part of creation and in our aesthetic nature. Personally this is experienced through creativity, through artistic expression, music and dance as bodily expression. I view that encouragement of creativity facilitates a more holistic response in people and therefore use this within education (Hall and Mitchell 2008, Mitchell and Hall 2008). I have been influenced by the work of Burkhardt and Nagai-Jacobson (2002) who suggest that the use of creative arts may specifically demonstrate the spiritual side of a person, both as 'doorway to and reflection of the soul'. Others write of this connection (Allen 2005, Howard 1998, Allen 1995, Cameron 1995, Henri 1984, Kandinsky 1977). Burkhardt (1994) also suggests that creativity may also be a specific aspect of feminine spirituality.

A question remains whether there is validity in attempting to define spirituality when the point of holistic care is to address the whole needs of the person. Defining spirituality as an entity, separating it from the whole, may thus move away from a holistic approach in health care (Goddard 1995). As explored above spirituality is regarded to be connected to the individuality of the person (Wojnar and Malinski 2003). This personal expression of spirituality is linked with my approach to health care, education and this study, which aims to consider the whole person and to bring people to completeness as part of the process. The above illustrates the complexity of my perception of individual spirituality and the links to holistic care and creativity.