

Section 9: Discussing the findings

I hold in my hand some pebbles. In journeying I recognise there are others of the same shape or hue. I begin to match them and see the patterns that each pattern brings...

This section will consider some of the selected issues raised in the material and relate this to current literature. The length of this thesis precludes exploration all of the issues in depth but I aim to include those most significant to understanding the key research questions.

9:1 Meaning of being a midwife

In research terms there have been few studies that have asked what it is like to be a midwife currently in the UK. For the midwives in this study being a midwife is meaningful and important, that it is related to their personal identity. In addition there were some differences between those who were working in the different areas of practice with concerns around division in the profession.

Midwifery as personal identity

The data from the material demonstrates the individuality of the midwives. The colours of the text quilts and stories showed how their focus for their careers in an holistic concept is related to their individuality. It is evident that these midwives saw the nature of their role as part of who they are; their personal as well as their professional identity. This was highlighted in a study questioning why midwives chose to return to practice, with almost half of the respondents indicating that midwifery was an 'important part of their identity' (Kirkham and Morgan 2006:107). In nursing terms professional identity has been defined as:

the nurse's conception of what it means to be and act as a nurse; that is, it represents her/his philosophy of nursing...More precisely, professional identity is defined as the values and beliefs held by the nurse that guide her/his thinking, actions and interaction with the patient. (Fagermoen 1997:435)

This concept of a philosophical framework underpinning the actions of the carer is applicable to the midwives, who voiced their values of belief in woman-centred,

holistic practice and normality. Such values are what they strive for in their practice but also recognising their own needs as women/midwives/carers. Within this they needed to balance their personal self that was also 'midwife'.

The midwives further described their identity in the role through their discussions around why they became midwives in the first place. Individual students will bring with them their values as they enter midwifery which may or may not alter through the education process. For students in a study about becoming a nurse there was recognition that nursing was something that they were 'supposed to do' or 'suited' to their character (Flaming 2006). This indicates a sense of 'vocation' toward this particular professional role, which was recognised in my study. This 'calling' was also identified by all the midwife participants in a study relating to the spirituality of childbirth (Linhares 2007) and in a study of the lived experiences of nurse-midwives (Doherty 2010). The concept of a 'vocation' was related originally to historical religious principles of being 'called' to a life of service (Lundmark 2007, Dawson 2005). This word has lost popularity historically with the move toward 'professionalization' of nursing and midwifery yet it is still recognised by those who are in the role. It has been argued that today's midwife needs to have a 'life time engagement as a social activist' (Daviss 2006:414).

'The calling' of the midwife has taken on a new dimension beyond preserving birth's sacredness. It is now a call to prepare women to walk through the health care system labyrinth with their integrity and faith in themselves unscathed. The credibility of the 'professional' part of each midwife hovers in her abilities, through research and clinical skills, to delicately portray for a woman how she can use less technology while the rest of the health care establishment is telling her she needs more (Daviss 2006:441).

The concept here is for current midwives to understand the 'professional' medicalised healthcare system and to use her 'calling' of being 'with woman' to be active for the woman and against the systems. Such arguments have implications for selection of students and education surrounding political awareness and activism.

Further complexity arises where some of the midwives indicated that they were hiding their identity through 'acting' in their role. Chris Bewley (2010:200) writes in her studies of midwives personal experiences where they have had no children or experienced loss, of them 'acting' and hiding their feelings. An anonymous journal article that tells of a midwife's ability to 'hide' her past history of

abuse (Anon 2010a), demonstrates how midwives could be 'acting' much of the time and hiding personal identity. It is evident here that there needs to be a balance between midwives dealing with personal need and professional boundaries in order to protect themselves psychologically. In addition I reveal the same issue in my reflections after receiving some painful family news.

November 3rd 2008

It is now making me think of midwives who are carrying their personal issues into work. How can we care for others if part of the space in our head is filled with other things? How easy it is really to compartmentalise ourselves when caring for others or is it possible to 'switch off' and to hold it in abeyance while the focus is on another? There is something here about the 'acting' role we have. I have been feeling that with my family life- that generally it is possible to 'get on with it and 'keep going' for everyone else- until something acts as a trigger to the pain



Such comments also have implications for selection of future midwives and education in enabling students to have increasing self-awareness of their needs to address personal issues that may affect their practice. This also raises issues of support for midwives in need, which will be discussed later in this section.

For the midwives in my study there was recognition that being a midwife was something that was integral to their personality, the choices they made in their lives as well as the values and beliefs indicated above.

Importance of being a midwife to them

I am challenged by Lizzie's earlier statement 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. For nursing it has been stated that meaningful practice:

'can be seen as arising from a) the expression of self in actualizing moral values through actions and interaction with patients in reaching the desired goals for each one; and b) the realization of more self-orientated work values through work performance, collaboration with other professionals and in personal outcomes. (Fagermoenn 1997: 436)

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'. In a study asking 'why midwives return' (Kirkham and Morgan 2006) the midwives wanted to make a difference to the women in their care and their colleagues, which was also indicated by Pamela in my study. The altruistic behaviour of those midwives based in a stand-alone birth centre is also noted (Walsh 2007a). Other research has identified that some midwives do not demonstrate this attitude of kindness or care (Dietsch et al 2010, Eliasson et al 2008, Halldorsdottir & Karlsdottir 1996). However, 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. In a nursing study (Fagermoen 1997:440) it was noted:

For most of the nurses in the survey and all the nurses interviewed, the value of altruism or care for the patients' health and well-being appeared to be an over-riding value, a moral point of view on which they based their practice. Furthermore, human dignity stood out as a core value, whilst all other values appeared to be linked to this basic value either by arising from it and/or being aimed at preserving it.

The importance of the role is also highlighted in the midwives' comments that being a midwife is 'more than a job'. It is clearly of value to them and they see it in terms of commitment of themselves as opposed to something they can leave when they go home.

In relation to this concept there were differences noted between those who were working in the hospital and community. 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. This is an interesting insight as all of these midwives have at some point been based in the community and have gravitated to hospital based working, often because of the need of family commitments. Why they have become less 'relationship-focussed' in their work role

maybe as a result of previous commitments into women's relationships or as a need to focus on the commitments of their family needs. Other studies also noted ideological differences between midwives working in the two areas (Hunter and Deery 2005, Hunter 2004). The potential may be that different 'types of personality' are choosing different areas of working.

Division in the profession

Further to the ideological conflict mentioned above the midwives also described clashes between midwives working in different areas of practice. The impression is given of a profession that is somewhat divided and in conflict within itself. These 'us and them' issues between midwives are not unusual and are also recognised through hierarchical relationships (Hunter 2005, Pollard 2005, Begley 2002). Poor relationships and bullying have been cited in the past as reasons for midwives to leave the profession (Curtis et al 2006). Midwives have also been accused of bullying students (Gillen et al 2009). Issues of relationships with obstetricians, anaesthetists and paediatric doctors are also noted (Downe et al 2010). In a Swedish study midwives recognise that over time there have been changes in relationships due to changes in roles of care assistants, and doctors, along with less opportunity to consult with and work alongside of other midwifery colleagues (Larsson et al 2009). Such relationships appear to have altered in the NHS, with subsequent impact on these midwives. Mavis Kirkham (2007) has suggested that the structure of maternity services and high expectations on midwives leads to frustration and bullying behaviour toward others. Billie Hunter (2005) argues for dealing with any 'paradoxes' relating to the 'fundamental ideological underpinnings of practice'. These behaviours are also apparent in a nursing context where Clare Hopkinson's (2010:258) study of a nursing ward demonstrates a culture of 'whinging' that leads to 'an environment of low morale, bullying and job dissatisfaction'. The cultural atmosphere may thus be perpetuating the behaviours of the workers. With the current increasing stress on midwives it is not clear how this will be resolved in the short term.

9:2 Art of practice

The midwives in this study talked of the art of practice as separate to the science, but also as integrated and interdependent. When creating the second pictures the community based midwives tended to focus on the 'normal' aspects of a

midwife's role as the art of their practice. For those in the hospital their pictures demonstrated a greater demarcation, with the art of practice more focused on 'normality' and the medicalised approach as more 'scientific'.

The midwives also recognised the significance of holistic, individualised care. One of the midwives states that some clients may need 'more art', which is an indication that individualised care needs to be flexible to the individual's needs. This may be more of a challenge in the current environment where midwives are expected to adhere to guidelines that put restrictive boundaries on their practice (Herron 2009, Larsson et al 2009, Pollard 2006).

Within the study the midwives also demonstrated recognition that a 'new art' is developing in midwifery, where midwives are adapting their skills to meet an increasing technology in hospital environments. They were indicating that augmenting labour, or the use of epidurals as a form of pain relief take a new set of skills in order for a midwife to create an appropriate environment for women to give birth. 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, of being 'with women' in these high technological settings as well as developing the more scientific skills,

9:2:1 Physical demands of being midwives

For these midwives there was recognition of the physical aspects of the role as well as physical demands upon them. They indicated how the excitement and stress of the role could be 'felt' physically. In Clare Winter's (2002: 92) study an independent midwife verbalised that she could 'feel the dilatation on my head' during a labour. Such physical 'feelings' by midwives are also supported by an American study (Davis-Floyd and Davis 1997:325).

The bodily aspects for midwives were also highlighted in the suggestion that behaviours and reactions were related to 'it's being a woman', implying hormonal changes experienced in relation to the menopause. There is currently no evidence related to the effect of the menopause on midwifery practice and limited in nursing (Keddy 1994). When it is considered that a large percentage of midwives are in the age bracket 45-59 (Midwifery 2020 Workforce workstream report 2010) there is potential that there are many whose physical changes are affecting their midwifery

role. If this is the case evidence is required around consideration of support of these midwives, especially relating to increasing levels of stress in practice. In addition evidence is required about the impact on decision making.

Working Environment

The midwives in this study highlighted issues and their working environment, which included community based situations, birth centres and hospital. It is known that the environment of birth is important to women (Newburn and Singh 2003). In a study of long-term memories of childbirth it was shown that women welcomed a 'calm, relaxing and quiet environment'. It was stated that:

' a cold atmosphere can also lead to a lack of connection with the midwife, and a feeling of loneliness,' (Lundgren et al 2009:121)

The working conditions appear to affect good care and also the self-development and wellbeing of the individual (Lövgren et al 2002).

The midwives related home birth as being significant for women and midwives. I identify with these midwives as I remember my personal story. Being at home for the births of my daughters was deeply meaningful and I valued the continuity of the relationship with the midwives who cared for us. I recognise therefore a bias toward community based care. Yet the majority of my working practice was spent in a high technological hospital based unit. My home and family remains key to me and the concept of the quilt that is evolving has connotations of 'homely' and 'womanly' arts (Ray and McFadden 2001). It is interesting to think how the beauty of the environment can affect the working practices of the midwife. I reflect on the use of textiles again as created to bring beauty to a place. For women these are significant and as most midwives are women the impact of the aesthetic area may be relevant. The concept of 'small is beautiful' is used by Denis Walsh (2007a) in his study of a birth centre which also had a 'home-like' environment, where the midwives had paid 'attention to detail...into preparing the birth space' (p113). In my study one of the midwives talked of 'being shut away' which is indicative of the need for a quiet space to give birth described by Michel Odent (2001). It is 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.

In relation to the hospital environment the midwives discuss the delivery suite coordinator, which is a significant leadership role. A study of this role in a New Zealand context shows the person to be:

an expert midwife in addition to being the leader, the broker, the mediator and the peacemaker; she can see the bigger picture and wisely takes action whenever required (Fergusson 2009:168).

There are obviously challenges here where midwives who have entered the profession with one idea in mind, of being 'with woman' is in conflict with the more hard-nosed managerial role of a delivery suite coordinator. Being able to run a unit in this way may not be every midwife's choice, whereas community based midwives are prepared to be more autonomous, running their own case load. There are implications to ensure greater focus on management roles in education setting.

Physical aspects of care

The role of the midwife was also described as a 'womanly art' with indication of the physicality of the issues: from vaginal examination at the start, to mentioning breastfeeding and sexuality. The art of midwifery is thus grounded in intimacy with women's bodies. Meeting a woman's need for hygiene and comfort is also regarded as important as an aspect of caring. This is reflected in a recent government report calling to return to the basics of caring (Prime Ministers commission 2010). Recognition of the physicality, intimacy, comfort and care in the role should be embedded in education.

Technological advances and approaches to midwifery care have been of concern (Larsson 2009, Davis-Floyd and Mather 2002, Wagner 1994). The midwives discussed equipment may be of value in certain situations; however they 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. With the 'ageing' population of midwives physical ability to use some of this equipment may become more challenging.

Time

For these midwives time is identified as required to ensure women get the best care, but recognise this is outside of their control. This has been identified in a number of studies (Stevens 2010, Fergusson 2009, Deery 2008, Walsh 2007a, Dykes 2005, Stapleton et al 2002). In addition personal time is being impacted through all the 'juggling' that is required, also noted by other research (Bryson and Deery 2010, Stevens 2010). The key to developing relationships is time (Kirkham 2010, Powell Kennedy et al 2004) yet it is evident midwives are getting less time to provide care and establish relationships (Carne 2011, Deery 2008). For community midwives there is conflict expressed between the need to build relationships with women and the requirement of management of time in order to improve cost effectiveness (Bryson and Deery 2010). Denis Walsh (2007a:62) suggests the need for a 'slow birth movement' to match the birth centre care he had observed, with a greater recognition of 'process' (biological) time, rather than linear (clock) time. Further authors argue that:

Slowing down may buy us some time to consider other possibilities, to do and be differently, or even to decide to stay as we are. We have little evidence to suggest that in all baby-having, fast is beautiful (Browne and Chandra 2009:32)

As the concept of lack of time appears to be an important issue for midwives over a number of studies it would be pertinent to explore how the issues may be addressed.

9:2:2 Psychological and Emotional

In recent years more interest has been shown in the emotional aspects of the working role of being a midwife (Hunter 2010, 2006, 2005, Deery 2005). Throughout this study I did not purposefully go out to find out about these emotional aspects. However during this journey it is evident I have recognised my own emotional responses in my reflections and that it is an aspect of my teaching to enable students to 'get in touch' with their feelings (Hall and Mitchell 2008).

Emotional responses

In the study the midwives expressed positive emotional responses of being a midwife in their role as part of their identity. Positive emotional responses are

therefore tied up in who they are and the pleasure they gain from the role. The midwives also demonstrate a need to mediate more distressing situations in order to cope with the role. It is expressed that, as a response to the attachment relationships midwives make, they may endure secondary trauma when these women have distressing experiences (Leinweber and Rowe 2010). They argue that enabling midwives to deal with this trauma will enable better care for women in the future. Having a previous nurse training may help in coping with such emotional experiences as it gives opportunity to deal with severe illness, death and dying very early in a health career. For some midwifery students they may have this opportunity in nursing situations now, but perhaps do not equate this with the possibility they may face death in midwifery. In addition some students may not face dealing with death in their training and therefore are shocked when having to face it as a qualified midwife. The implication here is that students and midwives may not be getting enough preparation for dealing emotionally with difficult situations. Increasing challenging medical situations within maternity units implies midwives may need more preparation in order to cope with them and dealing with their own emotions (Begley 2003, Mitchell and Catron 2002).

I reflect that over this journey of the study I have known a number of people who have died close to us as a family. Each of the situations has affected me deeply, and I have been in a heightened awareness of death and the significance of it as a woman. Being a 'caring' person I have 'been there' for the families concerned yet I have been aware how much this takes out of you, drains you.

Feb 19th 2010

Today is the first time I have felt able to pick this up after weeks of pressure from work and family issue. It shows that this study is so much of 'myself' and my emotional investment. I have been torn emotionally in so many different ways that I have not had the energy to explore the intensity of this. But out of this place of winter I can feel the surge of spring again and the buds are appearing...



It is indicated that midwives coping strategies are individually different and some may cope better than others. Suppression of emotions is known to have an effect on behaviours (Gross and Levenson 1997) which may ultimately lead to burn out (Firth-Cozens and Cornwell 2009). Midwives obviously work in challenging environments where they have to deal with both happy and painful emotional situations. They made comments about the need for greater support.

Need for support

It was felt that a smaller team is likely to be more supportive to each other. This was illustrated in a study about a small birth centre in how midwives care for each other in this environment (Walsh 2007a: 75). In this environment there was a higher degree of flexibility in working practices though with some challenging staff relationships. Overall it was regarded a place of community. The division between midwives discussed earlier demonstrates a culture lacking in support. Further examination needs to be made of why midwives are not supportive of each other when they are clearly meant to be supportive of women.

In addition the increasing amount of paper work appears to be leading to a loss in the midwife's supportive role. The view expressed regarding midwives missing the 'being with woman' aspect of care and being replaced by Doula's care needs to be explored further. It is well known that continuity in midwifery care is of benefit to women (Hatem et al 2008, McCourt et al 1998, Flint and Poulangeris 1987), and also brings satisfaction to midwives (Collins et al 2010, Hundley et al 1995). In areas where maternity services are not providing continuity of carer in labour women are turning to Doula's in order to provide that support (Lundgren 2010, Stevens et al 2010, Kitzinger 2008, Berg and Terstad 2006, Walters and Kirkham 1997). The structure of maternity services appears to be affecting midwives' ability to provide the support women desire.

The midwives relate issues around fear in pregnancy, which has been recognised as significant for many women (Otley 2011, Nilsson and Lundgren 2007). Enabling women to reveal those fears and aim to reduce them is an important role of a midwife, usually one who is based in the community (Hall 2007b). Postnatal care is also becoming more fragmented as there are cost cutting measures taking place. Archie's view that psychological support is important is often

discussed (Dennis 2005, MacArthur et al 2002) but not always accepted with postnatal care often marginalised (Carne 2011, NCT 2010).

Implications for education arise regarding ensuring support and care are key aspects of the curriculum. However students tend to mirror how they see mentors behave. If they are seeing poor support behaviours toward other members of staff or women in the units where they are placed they will also behave in this way. Lack of support was highlighted as an issue ten years ago (Kirkham 1999) and it is clearly an issue that has not been resolved.

9:2:3Spiritual issues

From previous sections it is evident that these midwives considered their role as giving them 'meaning and purpose'. They also consider giving meaning to women through the experience of pregnancy and birth and develop connecting relationships. Such issues have been identified as elements of spiritual care (Ross 2006, Hall 2001). As part of an holistic paradigm spirituality of the person should be considered and the midwives in this study mentioned this in relation to their role, the transforming nature of birth and intuition.

Spiritual care

In the current study, Sally-Ann views spirituality to be an integral part of being a midwife. She has an intense view of her role, which mirrors women's views of the spiritual nature of pregnancy and birth (Carver & Ward 2007, Jesse et al 2007). Independent midwives have also expressed the spiritual nature of their role (Winter 2002), and it is expected that spiritual aspects should be regarded as equally important as physical and emotional care (Midwifery 2020 Core Role of the Midwife Workstream 2010). A recent large online survey demonstrated that nurses recognise the importance of providing spiritual care (McSherry and Jamieson 2011). Limited evidence is available however relating to midwives concepts of spiritual care.

In this study the midwives equated spiritual care with establishing individual women's religious belief system and the need to provide appropriate care. Debates in the literature have taken place regarding the place of religion in relation to spirituality (e.g. Newsom 2008, Paley 2008, Pesut 2008, McSherry 2006, White

2006, Swinton 2001). Yet for women their religious belief is viewed as significant over pregnancy (e.g. Clark Callister and Khalaf 2010, Carver and Ward 2007, Clark Callister 2001, Khalaf & Clark Callister 1997). This indicates appropriate assessment should take place that will enable women to describe the relevance of belief to their experience of pregnancy. 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). Effectiveness of assessment will therefore depend on individual midwives.

'Caring' is also viewed as a sign of a spiritually aware person and the qualities of kindness, love and communicating it are outward signs of this. Principles of 'caring' and 'kindness' have been highlighted as important values of midwifery (Elliason et al 2008, Powell Kennedy et al 2004, Halldorsdottir and Karlsdottir 1996, Powell Kennedy 1995). Principles of maintaining dignity as a value of health care is currently in focus (McSherry 2010). From a medicine perspective it has been stated that dignified care requires a change in attitude and behaviour of the staff, increasing compassion and dialogue that acknowledges 'personhood beyond the illness itself' (Chochinov 2007).

Such depth of care is highlighted by the principles of 'caritas' (Watson 2008, Lundmark 2007) which appears to be an ability to care from 'higher/deeper dimensions of humanity' and 'human to human connections' (Watson 2008:35). The concept of 'Love' was also referred to by the midwives and as a principle of 'spiritual' caring (Watson 2003, Kendrick and Robinson 2002). Denis Walsh (2006) calls for midwives to return to 'nurture' and 'love' in their care along with a call to increase love and disturb birth less (Odent 2008). I note that there a number of squares on my quilt that show heart shapes as symbolic of love, as well as in the midwives' pictures. To me then love has been a significant aspect of my personal journey over this study and my life. Though this depth of care appears to be a welcome aspect what could be questioned is whether 'spiritually aware' midwives 'love' more or if loving behaviour is an indication of a sign of spirituality. Further questions relate to how these principles are taught, or whether they are learned through other methods (Hughes and Fraser 2010, Bluff and Holloway 2008, Mitchell and Hall 2007).

Intuition.

The midwives in this study referred to intuition as an important aspect of the

art of midwifery. For some this grew through experience, though it was acknowledged that some students and newly qualified midwives appear to have this ability. The relationship to professional experience and 'inner knowing' has been regularly debated (Jefford et al 2010, Olafsdottir 2009, Parratt & Fahy 2008, Davis-Floyd & Davis 1997, Rew 1989). Intuitive practice is suggested to be related to an 'inner connectedness' between the midwife and the woman (Davis-Floyd and Davies 1997) and 'trusting women's bodies' (Dahlen 2010). Clare Winter (2002:104) states:

Intuition, instinct and the subconscious work together to form a vital area of 'knowing'.

but that this is an environment where women and midwives are working together with 'trust and partnership' (p105). Intuition is regarded to be an aspect of 'expert' midwifery care requiring 'courage' (Downe et al 2007). However, Hannah Dahlen (2010:161) warns that:

'wishful thinking disguised as intuitive or women-centred care can be dangerous'

indicating that midwives should respond when situations are not 'normal'.

A number of questions arise from this. If being 'intuitive' is a good thing for the art of midwifery should we be selecting people to train with personalities who are more 'open' to being intuitive? If this is the case then how do we recognise this in potential candidates? Further should we be 'teaching' the ability to be intuitive to students? If so how do we actually get them to develop these skills, or do we leave this to chance over time in practice, as these midwives feel intuition generally develops over time? It is also not totally clear how intuition is linked to spiritual awareness; though it is evident situations are described that are 'unexplained' as far as the midwives are concerned. If these are linked then how can spiritual awareness be encouraged for the individual midwife effectively? Further investigation is clearly required.

Significance of birth

The midwives in this study discussed the importance of birth as a time of transformation for women and saw this as a powerful spiritual event. Studies and stories have recorded the intensity of women's views (e.g Clark Callister and Khalaf 2010, Wallas Chance 2002, Sered 1991, Hebblethwaite 1984). Birth is therefore significant to women and to midwives. The passionate meanings the midwives see

in birth may be a significant reason for keeping them in the role that is obviously a challenge to them. I reflect on this for myself and recognise my own feelings of the powerful nature of a birth, both as a midwife and a mother. Sunii Karll (2001) writes:

creating a birth of love and trust could influence an entire lifetime. Every birth contains this potential to make a difference. As midwives, this can be our highest offering.

She states that what happens at birth is significant to that child and her mother for the rest of their lives. Evidence is now available that suggests that the process of birth relate to the long term health of the infant (Hastie 2011). It has also been shown that changing a medicalised culture to one of 'humanized' care has the effect of 'transformation' for women (Misago et al 2001). Taking note of how we facilitate birth is therefore of importance across the entire holistic paradigm. The midwife's role is so important to get right and having a spiritual belief maybe a part of that.

9:2:4 Social issues

As with many studies relating to midwifery practice the issues of social relationships was important to the midwives in my study. This has been discussed earlier in relation to their concerns regarding how their time in practice is being eroded. They specifically referred to family relationships, alongside those of the women and their families. In addition they referred to relationships with women and their partners, including 'mothering', their public health role, and issues of trust and lying.

Personal relationships

Concepts of work-life balance has become an issue in recent years for midwives in the UK due to their altered demographic, increasing work load and increased part-time working. Historically midwives were single women and would work full time, often with little time off. The midwives in this study related aspects of 'juggling' they had to do in their lives to maintain both their family and career. In some case they had made choices about where they were working in order to reduce the stress of the balancing, including moving away from community work.

This is in contrast to many independent midwives¹ who successfully juggle family and commitment to the role as they are able to choose how many clients they take on and work with each other to support each other in times of need (Anonymous 2010b). The reality of the current high caseloads midwives carry in the NHS may be taking its toll on the midwives and forcing them back into hospital units in order to balance their family lives (Perinatal institute 2011).

It has been suggested that in order to progress in careers midwives choose between work and family commitments in order to achieve in the medical model (Henley-Einion 2009:185). She expresses concern at the number of older women entering the profession with families and their ability to cope. A study relating to Australian nurses and midwives has highlighted that poor consideration of their work-life balance leads to 'disengagement' in practice or leaving completely (Skinner et al 2011). Denis Walsh (2007a) was surprised during his study of a birth centre to see the presence of family members regularly. He suggests that this contributed to a more 'homely' atmosphere that created a better connection between people. It appears that working in a case-load model over time may enable midwives to balance their lives more effectively (Fereday and Oster 2010). Where midwives work, as well as how, is clearly a factor in their ability to balance their lives.

I identify with the need for balance in my life with work and family. The quilt is peppered with images of events that affected me and my family over the time of the study which included anniversaries, children's performances, holidays, illness, and death. The implications from this are to recognise the needs of midwives as 'whole' people, including those referred to earlier as well as their need to balance expectations from family. Not recognising their needs could lead to impact on their role as midwives or even losing them from the profession completely.

Relationships with women

These midwives saw their role as standing alongside women, the 'with woman' that the word midwife means in whatever setting they worked. They regarded the art of midwifery is related to establishing relationships in every situation. They found building relationships in community settings easier and viewed

¹ Midwives in the UK are able through law to set up and practise independently outside the NHS as long as they are working within the boundaries of the Midwives' rules of practice (NMC 2004)

important recognising individuality of women. However they also viewed the different skill of building 'speed' relationships as important. These statements are common to other literature exploring the role of the midwife (eg Kirkham 2010, Hunter et al 2008, Hunter 2006, Walsh 2006, Hildingsson and Haggstrom 1999, Fahy 1998). In a case-loading model women describe the midwives as 'friends' with midwives 'going the extra mile' in order to provide support and resolve difficulties (Walsh 1999). Midwifery is thus viewed as being grounded in relationships with women. This in turn is seen as being valuable and beneficial (Devane et al 2010). The implications for education is that students need to be taught appropriate communication skills and we choose students who are more likely to be able to build relationships and communicate effectively (Midwifery 2020 Core Role of the Midwife Workstream 2010).

Public health role

The midwives also highlight the importance of the public health role to them, and being part of a community of women which has until recent times been overlooked (Chief nursing officers 2010, Midwifery 2020 Programme Public Health Workstream 2010, National Collaborating Centre for Women's and Children's Health 2010). However it could be argued that the historical role of the midwife has been as a public health educator (Marland and Rafferty 1997). Midwives have always been part of community areas and therefore recognising social need. Over time control of midwifery care has been taken away from community areas but community based midwives have remained pivotal in educating for health, as well as communicating with other members of the primary care team. The public health agenda is one that will need to be addressed increasingly in education though it could be debated how the current political climate will enable this role to be advanced.

Partner relationship

The relationship with the male partner was also mentioned as significant by the midwives, in both community and hospital settings. It involved being able to communicate effectively with partners and recognise when their presence in a situation was not helpful. In the past fifty years in the west the presence of partners at birth has become acceptable and is not expected in all cultures. Challenges to the power exerted by men in the birth room as well as concerns about the psychological

effects on men being present at birth have been made (Odent 2009). However this has a significant agenda currently in the UK with pressure from men to be more involved in pregnancy and birth (Fatherhood institute 2008). In a study relating to childbirth it was noted that there were differences in the 'presence of the partner' and that of the midwife (Lundgren et al 2009). However some women feel lonely and insecure even with a partner present at birth and with feelings of abandonment by the midwife. They suggest that the roles are both different and complementary.

Mothering by midwives

One of the midwives referred to the concept of 'mothering' women. This is an interesting concept as not every woman wants to be 'mothered' particularly if they have had poor experience of their own mother. In a study relating to midwives' support of women (Hildingsson & Haggstrom 1999) the authors relate:

The midwife could, therefore in the terms of a comprehensive understanding, be seen as a deputy mother, who, not for her own sake but for the babies, becomes an involved advocate in difficult situations. 'The Good Mother' in this sense must sometimes admonish, sometimes arrange things for her children, and she must also be able to encourage the children to manage their own lives and leave them alone when they can. To be a 'Good Mother' demands an involvement that can be both emotionally exhausting and time-consuming but also joyful (p88).

Denis Walsh (2006:237) also refers to this 'mothering' role of midwives in a birth centre, using the term 'matrescence' which he states is 'a skill in facilitating the 'becoming of a mother' (p237) and appears to be connected with 'selfless love'. However it may be a concept that is being lost in midwifery as partners are more often present in the room with the intention they provide the support that's needed, or doulas are employed to support as midwives are not perceived to be so available. In addition this has implications for selection of students, as some women may be regarded more 'motherly' than others. It could also be questioned how this 'motherly' attitude is taught, or whether it is related to the personality of the person, as discussed in a previous section.

Trust and lies

The midwives in this study considered 'trust' to be significant in relationships with women. This is a common subject in studies relating to midwives. In case load

care there were high levels of trust between the women and midwives (Walsh 1999). It is also regarded as a value of the 'expert midwife' especially as:

'both a consequence and a cause of the strong belief in normality'
(Downe et al 2007).

Trusting and reciprocal relationships are also created as a result of providing continuity of carer and getting to know the women (Hunter 2006). It is therefore surprising that the midwives also referred to 'lying' as midwives both to professional colleagues and to women.

These issues have been written as 'doing good by stealth' (Kirkham 1999) which is also reflected in Mary Stewart's (2005) study related to vaginal examinations. This behaviour of 'little white lies' is proposed to be used as a way of protecting women when in labour from intervention by doctors and avoiding working to hospital guidelines. It has been suggested that the increasing use of 'prescriptive interpretation of guidelines' such as those by NICE, encourage this behaviour in midwives (Walsh (2007b)). In addition the midwives stated using this when they feel a woman has 'had enough' in labour and need intervention.

It is not clear how widespread this activity is but, it may have increased since the introduction of more controlling guidelines as suggested by Denis Walsh above. However this raises significant implications. By not acting according to the clinical judgement of the midwife 'lying' will lead to midwifery knowledge such as intuition within the art of practice being buried as it is not discussed openly. Professional lying also interferes with the trust of the women of midwives. Questions could be asked by women such as: is she always telling me the truth about what is happening to me or 'making things up' so that she can rush home? It also interferes with trusting relationships with the medical profession as it could lead to doubt of what is being communicated. It is to be questioned where midwives learn this behaviour and whether it is then being passed onto the following generations of students. In order to provide the art of midwifery women need to be able to trust midwives and midwives need to learn more to trust women's bodies and the process of birth.

9:3 Final Statement

From the discussion above it is evident that midwifery is bound in personal meaning for these midwives and has kept them in the role through considerable

change. The concept of a 'salutogenic' approach, or the 'generation of well-being' has been postulated for changing practice in normal birth (Downe and McCourt 2008). Based on the work of Aaron Antonovsky they highlight that those with a high level of well-being have a 'sense of coherence'. The components of this are:

1. **Meaningfulness:** the deep feeling that life makes sense emotionally; that life's demands are worthy of commitment. It is essentially seeing coping as desirable.
2. **Manageability:** the extent to which people feel they have the resources to meet the demands, or feeling that they know where to go to get help.
3. **Comprehensibility:** the extent to which a person finds or structures their world to be understandable, meaningful, orderly and consistent instead of random and unpredictable. Paradoxically, a strong sense of coherence appears to help individuals cope with chaos and uncertainty where they do encounter it. (ps20-21)

Though suggested for women and birth these principles could also be applicable to the midwives in this study who have clearly the commitment, resources and ability to cope through continually changing and complex circumstances.

The sections above have discussed some of the issues raised by the midwives in relation to the holistic framework of the study. In relation to my quilt I view each of the squares made tells a separate story but they are still fundamental to the whole piece. For the sections above it is evident that, though separate, the aspects of the points raised are integral to each other as well as affected by each other. The personality of the midwife may result in the choice of area where she works but may be affected by her family commitments. Though she may desire to make strong, trusting relationships with women, this may be affected by the environment where she works which may also affect her ability to use her intuitive responses. Each section should not be taken in isolation. This demonstrates that being a midwife and the art of midwifery practice are areas of complexity and may not clearly be demarcated into linear answers. Instead the process of bricolage and creative inquiry reveals the multidimensional layers of the role and of the individual in an ever changing environment.