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UNIVERSITY OF SAN DIEGO  
Hahn School of Nursing and Health Science  
DOCTOR OF PHILOSOPHY IN NURSING

AN INTERPRETIVE EXPLORATION OF THE  
MEANING OF BEING WITH WOMEN DURING BIRTH FOR MIDWIVES

by

Lauren P. Hunter

A dissertation presented to the  
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE  
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the  
requirements for the degree  
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March, 2003

Dissertation Committee

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**May, 2003**

**Lauren P. Hunter**

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## Abstract

This study explored the meaning of the phenomenon of the midwife's experience of being present with a woman during childbirth. The value and importance of being with a woman during childbirth, specific and unique to midwifery care, is reflected in midwifery philosophies and models of care. This study looked through the lens of midwives who have written poetry about births they have attended to learn more about the experience of being with a woman.

Hermeneutical phenomenology was selected for the philosophical methodology and method because it looked at both the phenomenon and the use of language to describe the phenomenon. The researcher reflected upon and interpreted 18 selected poems as data and developed themes, which described the midwives, lived experiences of being with a woman.

The data revealed that being with a woman was a key phenomenon that permeated all the themes developed from the interpretation of the poetry, *spiritual connections*, *experienced guidance* and *partners in birth*. Themes consisted of midwife actions or beliefs, or both about the phenomenon. The researcher also discovered three authoritative ways of knowing that guided the amount of presence the midwife provided to women during childbirth. They were self-knowledge from the belief system of the individual midwife, grounded knowledge through personal lived experience with childbirth, and informed knowledge from objective and scholarly sources.

Themes from the poetry that were supported by midwifery models of care and informed knowledge such as *safety and protection* were also valued by the dominant

medical paradigm as legitimate knowledge. Themes from the poetry that were supported through effective knowing such as *handwork and succoring connections* were important to recipients of midwifery care and considered legitimate knowledge in personal narratives and stories written by midwives.

This study found that being with a woman during childbirth is an important aspect of midwifery care. Certain aspects of being with woman such as the midwife's connection to and use of spirituality and the use of touch require further inquiry. Midwives need to support midwifery knowledge as a legitimate form of knowing and being with woman as a legitimate form of caring in the provision of care to women.

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## CHAPTER 1

The word midwife is derived from old English and literally means “with woman” (*Random House Webster’s College Dictionary*, 2000, p. 840). The phenomenon of *being with a woman* is a trademark and tradition of midwifery care. The concept of being with a woman has been supported by midwifery literature and theory as a unique and important essence of the profession (Hunter, 2002b). The milieu of the current hospital environment, where approximately 96% of all nurse-midwifery attended births occur, discourages midwives from practicing the midwifery model of care that includes the time to be with a woman during childbirth (Ventura, Martin, Curtin &, Mathews, 1998). It is paramount that the profession of midwifery learns as much as possible about the phenomenon of being with women so that it can remain a major tenant of midwifery care. The concept of being with women must be incorporated into hospital policies and procedures where most midwives practice. This chapter will provide the purpose of the study and how the study was conducted. The significance of the phenomena and the rationale for the study will also be discussed. The underlying assumptions that will affect the course of the research will conclude this chapter.

### Purpose of the Study

The purpose of this study was the exploration of the meaning of being with woman for midwives as they attend women during labor and birth. The researcher attempted to look through the lens of midwives who have written poetry about the births they have attended. Their thoughts on their experience of being a midwife, as expressed in poetry, were analyzed to discover more about the phenomenon of being with a woman during childbirth. The researcher hoped to gain a clearer understanding, of those aspects of the midwife's lived experience of being with a woman during childbirth that were essential to the phenomenon.

### Format of the Study

Poetry written by midwives about midwife attended births or being a midwife was used as data for analysis. Hermeneutical (interpretive) phenomenology was the method used to develop themes from the selected poetry, which reflected the midwives lived experience of being with a woman. Hermeneutical phenomenology was selected as the methodology for this study because it looked at both the phenomenon of the study and the use of language to describe the phenomenon. van Manen (1997) defined the hermeneutical phenomenological methodology as a descriptive (phenomenological) methodology because the lived experiences were meaningfully expressed through language. It was a hermeneutical methodology because all phenomena could be interpreted through language. The researcher reflected upon and interpreted the poetry as data in order to answer the following research question: What is the meaning of the phenomenon of being with a woman during childbirth for the midwife as she lives the

experience? Themes were isolated from the poetry through reflection upon the poems as a whole, and via verses, metaphors, and individual lines of prose. The interpretation and reflection resulted in a linguistic transformation of the data into a readable narrative that was credible and true to the phenomenon of study (van Manen, 1997).

### *Significance of the Phenomenon for the Profession*

Historically women have always been present with women during childbirth. Prior to the advent of modern obstetrics and technology, a human presence was all that could be offered as assistance to a laboring woman. Midwives believed the phenomenon of being with a woman in labor was a specific and unique part of midwifery care. Its importance was noted not only in midwifery philosophy but also in its incorporation in the development of midwifery theory over the last twenty years. Documents pertaining to midwifery philosophy from international sources (Guiland & Pairman, 1995) and professional organizations (American College of Nurse-Midwives [ACNM], 1989) all confirmed the midwives' belief that it was important to be present and available to women during childbirth. Being present and available to the woman during childbirth was and is an important action for the midwife to practice within the midwifery model of care (Hunter, 2002b). Current midwifery theory included the continuing presence of the midwife as an integral concept of the midwifery model of care (Dickson, 1996; Kennedy, 1995, 2000; Thompson, Oakley, Burke, Jay, & Conklin, 1989).

In addition, worldwide organizations specializing in maternity issues have supported the right of every woman to have a skilled woman available to them during childbirth (The Maternity Center Association 1998; Coalition for Improving Maternity Services, 1997). However, one important distinction to be made, from the researcher's

point of view, was the type of skilled woman that should provide the needed human presence. The researcher believed that midwives are uniquely suited to provide a sustaining human presence during childbirth because of their philosophy, model of care and clinical competence. Currently there are three types of professionals that might be available to provide a skilled human presence during childbirth: the midwife, the nurse and the doula. In the mainstream North American health arena, research demonstrated that nurses no longer routinely provided support during labor (Gagnon & Waghorn, 1996; McNiven, Hodnett, & O'Brien-Pallas, 1992). The midwives most frequent current environment for practice is within hospital settings that emphasize a medical model of care that jeopardizes the ability to practice the phenomenon of being with woman. Increasingly, midwifery has been forced to practice under administrative health policies that do not value or understand the time intensiveness of being with a woman. This is incongruent with evidence-based knowledge citing the benefits of a sustaining human presence during childbirth (Hodnett, 2000).

Midwives have worried that technology, especially in the hospital environment, was considered to be more important than caring by those who provide childbirth services (Buus-Frank, 1999; Oakley, 1989). Midwives fear that the trademark of their profession, being with a woman, would disappear if the trend toward technology were to continue. For instance, hospital health policies mandate one-to-one care for patients who receive the drug oxytocin because of the very small risk of uterine rupture. However, if a laboring woman does not require technological interventions, such as oxytocin or continuous fetal monitoring or chooses not to use interventions, she is often part of a midwifery caseload of three or more patients. It is difficult for a midwife to practice the

phenomenon of being with a woman to the clients if they must care for too many laboring women simultaneously.

The midwife's difficulty in providing a continuing presence while practicing under the medical model of care has led to the profusion of a third provider of human presence, the certified doula. The doula's role is to provide the educational, emotional and physical support to the woman in labor that used to be the exclusive domain of the midwife (Simkin & Kelli, 1998). Typically a doula received a short period of training about childbirth and labor support techniques in addition to actual preceptoring at births. The doula, a newcomer to hospitalized childbirth, is paid by the pregnant woman to ensure that she receives labor support. Doulas can be helpful to the laboring woman and work synergistically with the midwife. I feel that it is imperative for the practice of being with a woman to remain in the midwives' repertoire of care. Therefore, it was paramount to learn more about the phenomenon of being with a woman from the midwife's perspective.

It was important to learn more about what constitutes being with a woman so that it could be used to a greater advantage during childbirth. If the phenomenon of being with a woman could be more clearly defined it would also be easier for health care administrators to encourage its use as a modality of care during childbirth. A clearer understanding of the phenomenon would help midwives address such issues as the value of midwives being with a woman, ways to facilitate the opportunities for the midwife to be with a woman, and how much availability of presence and companionship would be needed to meet women's needs.



Being with a woman is unique to the profession of midwifery (Kennedy, 2000). In order to preserve it as an integral component of midwifery, that is helpful to woman during childbirth, more must be learned about its composition. This study looked at the midwife's experience of being with women through a unique type of data, poetry written by midwives, in an effort to learn more about the phenomenon. It was believed that if more could be learned about the essence of being with woman through inductive research, the phenomena could be used more effectively in practice by midwives and be sanctioned as a legitimate and valued type of care by hospital administration.

### *Significance of the Phenomenon to Research Inquiry*

To my knowledge this was only the fourth study in nursing and the first in midwifery to use poetry as a source of data. In addition, I believe that this was the first study to specifically explore the phenomenon of being with woman from the perspective of the midwife.

Kitsinger (1991) felt that everyday emotions were intensified by the birth experience. This was true for both the woman experiencing the birth and those present during the experience such as family members and care providers. I believed that valuable information about being with women could be gained by using poetry as data for analysis for three reasons. First, people who have a need to express themselves via written text about a profound or emotionally intense experience wrote poems. Second, childbirth was a profound and emotionally intense experience. Third, poetry was an excellent medium for human expression of experience as it relied upon evocative and effective meaning. To put it bluntly, no one sits down and writes a poem about childbirth unless it has been a profound and emotionally intense experience. Therefore, the themes

that were generated by my interpretation of the data should reflect core essences of the phenomenon.

## Assumptions

### *Ontological Assumptions*

Meaning is derived from the individual's interaction with an experience or situation. The subsequent interpretation is a fusion of both (Weinsheimer, 1991).

### *Personal Assumptions and Beliefs*

Birth is a normal process and significant life event. Being with a woman facilitates the birth process and experience for the woman and her family. Being with a woman is an integral and unique aspect of the midwifery model of care (Burst, 1990; Kennedy 2000; Thorstensen, 2000). The concept of being with a woman has not been valued by the dominant medical /obstetrical paradigm (Arms, 1975; Davis-Floyd, 1992, 1994; Gordin & Johnson, 1999; Haire, 1972; Howell-White, 1959; Kirkman, 1997; Jordan, 1997; McKay, 1991)).

My personal beliefs, lived experiences and philosophy have influenced my interpretation of the poetry used for this dissertation. I believe that every laboring woman should be offered the opportunity to have a nurse or midwife's presence during childbirth.

Poetry about childbirth was a unique medium for exploration of the meaning of being with a woman. This was true because the writing of poetry was not an everyday or common experience for most people. In order for a person to write a poem about childbirth several events must occur. First, there must be a significant experience that

stayed within the person's consciousness. Secondly, the person must have felt so strongly about the experience that she took the time to reflect, interpret and write about the experience in a poem.

## CHAPTER 2

### LITERATURE REVIEW

This chapter provides a review of the literature about the concept of being with a woman. The nature of poetry and its' contribution to the profession of nursing and midwifery are discussed. As part of the qualitative process van Manen (1997) stressed the use of literature as a method of inquiry into the exploration of an experience.

In the first section of the chapter the concept of being with a woman was explored to enhance the understanding of its meaning. The etymological origins and definitions of being with a woman are then identified and discussed (van Manen, 1997). The concept of being with a woman and its relationship to midwifery philosophy, theory and research follows. A physiological basis for being with a woman is presented in the next portion. Two related and probably similar concepts from the literature regarding social support in labor and being present are examined for their contribution to the understanding of being with a woman.

In the second portion of the chapter literature will be reviewed that contributes to the understanding of poetry. Poetry's contribution to nursing will then be reviewed. The final section of the literature review examines poetry written by nurses, poetry's effect on the profession, and its use in education, patient care, and research.

## Definitions

### *Definition of Midwife*

A midwife has been defined by as a “person who assists women in childbirth” and “to assist in producing or bringing about something new” (*Random House Webster’s College Dictionary*, 2000, p. 840). Midwife comes from old English: “mid” meaning with and accompanying, and “wif” as wife/woman. This definition made historical sense since midwives were usually women (wives) who had born children themselves. The word woman has universally recognized meaning. Woman has been defined as “adult human beings who are biologically female, that is, capable of bearing offspring” (*Random House Webster’s College Dictionary*, 2000, p. 1500).

### *Definition of With*

The concept of *with* is a complex preposition with numerous definitions. For the purpose of this research the following definitions will be used. *With* is a form of accompaniment, implying an interaction, a particular relationship or connection whereby participants display the same opinion or conviction. *With* also implies a spatial sense of proximity (*Random House Webster’s College Dictionary*, 2000).

### *Other Uses of Midwife*

A comprehensive literature search revealed that the use of the word *midwife* (aside from nursing and midwifery) was found only in veterinarian medicine where it was used as a colloquialism for assisting in animal births. In addition, Belenky, Clinchy, Goldberger, & Tarule (1986) coined the term *midwife–teacher*. Attributes of a midwife–teacher were supporting and encouraging students, but not thinking for them. Midwife–teachers “assist the students in giving birth to their own ideas, in making their own tacit

knowledge explicit and elaborating it” (p. 217). Midwife-teachers were present and available, but did not tell the student what to do or how to think.

### Midwifery Philosophy

Regardless of the type of midwife or birth setting all midwifery practice philosophies reflected the concept of being with a woman during childbirth. The International Confederation of Midwives (ICM) based its philosophy on a partnership between the midwife and client (Guiland & Pairman, 1995). The philosophy of the American College of Nurse-Midwives ([ACNM], 1989) stated the importance of the provision of emotional and social support. ACNM’s core competencies (1997) stressed the importance of the therapeutic value of human presence. The recent findings from the Pew Health Commission for midwifery reaffirmed this philosophy and stated that part of the midwifery model of care was continuous, hands-on assistance during the childbirth process (Dower, Miller, & O’Neil, 1999).

Frye (1995) defined a lay midwife as one who advocated homebirth and emphasized a holistic approach for practice of midwifery. Midwifery was female-centered and integrated. Being with a woman required the midwife to be a skillful guide who supported and assisted the woman by being present and engaged with the client in a one-to-one interaction. Kaufman (1993) discussed issues regarding the woman’s sense of control and the use of medicalization during childbirth. Kaufman summed up being with a woman as a presence that included physical, emotional, and psychological realms.

It should be noted that the importance of the concept of being with a woman was not specific to midwifery. The Maternity Center Association (1998), an 80-year-old non-

profit watchdog agency for maternity concerns, stated that the consistent presence of a supportive provider during labor and birth should be a guaranteed right for all women. Further, the Coalition for Improving Maternity Services, (1997) who promoted a wellness model of care, espoused the same beliefs concerning unrestricted access to continual emotional and physical support from a skilled woman.

### Midwifery's Theoretical Perspective

Theory building in nurse-midwifery is a relatively new phenomenon, which began approximately 15 years ago. Five studies and manuscripts were identified that could contribute to the knowledge base of being with a woman.

Thompson, Oakley, Burke, Jay, & Conklin (1989) marshaled the first efforts to define midwifery care by developing a middle range theory of the nurse-midwifery care process. The underlying ACNM (1989) philosophy of nurse-midwifery formed the basis for the initial key concepts of the theory. Next, an interdisciplinary panel of expert certified nurse-midwives (CNM), nurse researchers, consumers and nurses examined a combination of videotaped nurse-midwife- client interactions to identify examples of midwifery care. The CNM responded to survey questionnaires to further develop the components of the initial concepts. *Satisfying*, one of the six final concepts identified for nurse-midwifery care, contained attributes of being with a woman that included physical and emotional support during labor.

Lehrman (1988) developed a theoretical framework for intrapartum nurse-midwifery practice that described the relationships between components of nurse-midwifery care, psychosocial health outcomes and maternal psychosocial variables. A

sample of birth center clients was used in this non-experimental, correlational, prospective study that obtained measures in the third trimester of pregnancy and one month after birth. Through this research an extensive definition for the concept of positive presence was developed and summarized as “one on one personal attention and constant availability of the nurse-midwife for the woman in labor” (p. 44). The study stated that a positive presence by the nurse-midwife increased a woman’s self-esteem and satisfaction with the labor experience.

Kennedy (1995) conducted a phenomenological study of nurse-midwifery care from a feminist perspective, with the belief that midwifery provided care *with* women not *to* women. Participants from two large practices with ethnically and economically diverse clients were interviewed. The birth settings varied from a high technology Level III setting to a low technology Level I hospital. Kennedy formulated nine essential themes. Though many of the themes had characteristics of being with a woman, one theme, “a continuous link with the nurse-midwife” was the most representative (p. 415). The participants perceived this to be continuous care and support and “a presence that was felt and valued” (Kennedy, 1995, p. 415).

Kennedy (2000) furthered this research using a Delphi analysis that described exemplary midwifery care. The study was grounded in critical and feminist theory as well as theory on establishing domains of work. Two groups were sampled: midwives and recipients of their care. Three dimensions of midwifery emerged: (a) therapeutics, (b) caring, and (c) the profession. Maintaining a supportive presence and staying with the woman in labor, with adequate time to meet the woman’s needs, were processes of caring that reached strong consensus among the recipients of the midwifery care group. Stories



by both groups supported the general theme of the “art of doing nothing well.” This theme was described by the midwives as supporting normalcy, being present and not intervening unless necessary. Recipients’ descriptions included “being there” and “someone who rode the river with me” (Kennedy, 2000, p. 10).

Dickson (1996) developed a theoretical model for midwifery based upon feminism, caring concepts, and holistic nursing. The components of midwifery caring included the concept of presencing. Dickson described presencing as *being with* on both emotional and physical planes. The theory also emphasized spiritual care as a component of the model. Dickson stated that midwives were in a unique position to provide spiritual care because of the midwife's sensitivity to and personalization of the birth experience.

### Physiological Basis

#### *Catecholamines and Labor*

Limited research was found on the physiological rationale for improved outcomes when a supportive presence was provided during childbirth. Anxiety, pain and fear were known to increase catecholamines. Research has demonstrated that a sustaining human *presence* decreased the anxiety, pain, and fear a woman might experience in labor (Klaus, Kennell, Robertson, & Sosa, 1986; Sosa, Klaus, Robertson, & Urrutia, 1980). Animal studies have shown that increased levels of catecholamines reduce uterine and placental blood flow, which perhaps contribute to pain (Adamson, Meuller-Heubach, & Myers, 1971; Barton, Killam, & Meschia, 1974). Human studies have found that cognitive concerns, pain, or anxiety concerning labor resulted in increased levels of catecholamines

and longer labor with slower rates of uterine dilatation (Lederman, Lederman, Work, & McCann, 1985; Wuitchik, Bakal, & Lipshitz, 1989; Zuspan, 1962).

### *The Effect of Touch in Labor*

Saltenis (1962) studied the effect of nurses' *high touch* (hand holding, stroking) as an effective tool for nursing support in labor as opposed to *clinical touch* (assisting with position changes and palpating contractions). Twenty-one primigravida women in active labor were used to test the hypothesis regarding the effect of touch. *High touch* improved the woman's coping ability and sensation of comfort and, physiologically, produced decreases in the systolic blood pressure and pulse.

### Research Relating to Midwifery

Prior to starting the review of literature certain areas must be clarified. First, the concept of being with a woman was considered specific to the midwifery model of care. However, because the definition of being with woman encompassed so many domains, physical, psychological, spiritual and emotional, many of the attributes of the concept may be found in other phenomenon. Further, because the concept was based upon a woman's perceived needs and desires during childbirth it will always be a slightly ambiguous phenomenon. In addition, midwives and other providers, physicians, nurses, doulas, family members, with one's own theoretical and philosophical frameworks provide care for women during childbirth. In general, being with woman, as a midwifery concept, was defined as presence by midwifery/nursing professionals, labor support by doulas, and social support by obstetrical care providers.

## Women's Experiences of Midwifery Presence

Current research in midwifery did not address the specific concept of being with a woman during childbirth. However, findings concerning this concept have been found imbedded in recent qualitative studies that explored women's experiences of labor and birth with midwife care and women's satisfaction with the childbirth experience.

### *Positive Attributes of Being with a Woman*

Research that examined women's perceptions of a midwife's presence or the experience of being with a midwife demonstrated two types of providers: a caring and a non-caring midwife (Halldorsdottir & Karlsdottir, 1996a). Traits of a caring midwife included the attributes of being with a woman and presence. The attributes of an uncaring midwife were identified as the absence of presence, feeling of lack of support, lack of competence, followed routines and rules, coldness, and harshness. Their phenomenological study identified the following caring attributes congruent with being with a woman: undivided attention, sharing the course of events, touch, professional intimacy, connectedness, and support. Interestingly, part of being a caring midwife also included professional competence. Frazer, Murphy, & Worth-Butler (1996) found that the traits of presence were described as being expert in human touch, communication and active listening, discretionary privacy, and professional judgments. Their study utilized a convenience sample questionnaire to learn what constituted a "good midwife" from recipients of midwifery care.

Berg, Lundgren, Hermansson, & Wahlberg's (1996) phenomenological study found that the essential structure of the midwifery experience was the midwife's presence. Three sub themes of presence were identified: (a) the midwife's ability to see

the client as an individual, (b) support and guidance based on the client's desires, and (c) a trusting relationship. Walker, Hall, & Thomas (1995) also developed themes from post delivery interviews with women cared for by midwives. One of the generated themes, perceived support, included someone who provided confidence and who could be trusted.

#### *Women's Description of Positive Interactions*

Ten other qualitative studies have looked through the lens of women's experiences with midwifery care. What women wanted or associated with a positive birth experience with their midwife were a caring, trusting, and flexible relationship with shared responsibility, co-participation and midwifery guidance, and companionship. Support from the midwife; sensitivity to needs and reassurance were also valued by laboring women. Other themes that were supportive of the concept being with a woman from the woman's perspective were clinical expertise, control in decision-making, and advice and information from the midwife (Berg et al., 1996; Bluff & Holloway, 1994; Hall & Holloway, 1998; Halldorsdottir & Karlsdottir, 1996b; Lavender, Walkinshaw & Walton, 1999; Leach, Dowswell, Hewison, Baslington, & Warrilow, 1998; Tarkka & Paunonen, 1996; Too, 1996; Waldenstrom, Borg, Olsson, Skold, & Wall, 1996; Walker et al., 1995; Walsh, 1999).

Lehrman (1988) defined positive presence as the "the extent to which the nurse-midwife's response to the laboring woman encompasses the high touch qualities of nurturance, intuitive awareness, sensitivity, personal attention, knowledge, professional expertise, and presumed validity of the individual woman's subjective experience" (p. 44). Qualitative studies of the childbearing women's perspectives and experiences of childbirth with midwives have demonstrated that women value the nurse-midwife's

concept of being with a woman. None of the above studies were conducted in the United States and this underscored the need for further research concerning women's experiences of nurse midwifery presence in this country.

### Social Support, and Being with a Woman

It is critical to review the research on social support in labor, a concept identified in obstetrical literature, for two reasons. First, the definition of social support was virtually the same as that as being with a woman. Variations on the definition included numerous attributes such as physical touch, comfort, emotional support, information giving and helpfulness in professional fields such as psychology, nursing, and sociology. The theoretical bases also included factors such as caring, communications, relationship, and advocacy. Secondly, numerous quantitative studies have been conducted that demonstrated a definite association between social support in labor and beneficial maternal/neonatal outcomes (Hodnett, 2000). Social support, as defined by Hodnett (2000), was "the three dimensions of advice/information, tangible assistance, and emotional support (presence, listening, reassurance, affirmation)" (p. 2). A willing relationship between the giver and recipient of care was also implied.

### *The Concept of a Doula*

In the 1980's two important studies were conducted in Guatemala. These studies demonstrated how the presence of a continuous supportive female companion, a doula, during childbirth reduced the rate of cesarean section, increased maternal-newborn bonding and shortened the time of labor (Klaus et al., 1986; Sosa et al., 1980). The word *doula* was of Greek derivation and meant an experienced female who guided and assisted

a new mother (*The Random House Webster's Dictionary*, 2000). Typically, a doula was a woman that had been professionally trained to provide labor support to a woman and her family during childbirth. Doulas did not perform medical or clinical tasks. These studies were randomized and controlled studies and physicians believed it was important to replicate them in the United States under modern obstetrical conditions. If the findings were similar the practice could be applied to obstetrical care in the United States. The biggest differences in obstetrical practices between the two countries was that in the United States practitioners used an increased amount of interventions and technology such as electric fetal heart rate monitoring, epidural anesthesia, oxytocin, and artificial rupture of membranes to augment labor (Kennell, Klaus et al. 1991).

Kennell, Klaus, et al. (1991) replicated the randomized and controlled studies in the United States with a sample of 412 women experiencing their first pregnancy. A doula stayed with the woman during labor, providing touch, encouragement, information and explanation of hospital procedures. Doula support significantly reduced the rate of caesarean section and forceps delivery for the experimental group. In addition, the use of social support decreased oxytocin use, shortened the duration of labor, lessened prolonged infant hospitalization, and decreased the chance of maternal fever.

Three studies (Klaus et al., 1986; Sosa et al., 1980; Kennell, Klaus et al., 1991) were significant because their prospective nature and quantitative method allowed the effect of continuous social support to be isolated from other variables. Kennell, Klaus et al., (1991) concluded that a continuous presence was emotionally and physically beneficial to the mother.

### *Conflicts Within the Medical Setting*

The results of the above studies have not been used as a guide for women's health care and policies in the United States. Instead of instituting social support via a midwife or doula to enhance beneficial childbirth outcomes, the obstetrical community in the United States has chosen to use more technologically and biomedically based interventions. A prime example of this was the adoption by many hospitals and care-providers of part of the *active management of labor system* advocated by England's O'Driscoll & Meagher (1980) and O'Driscoll, Foley, & MacDonald (1984). This three-pronged active approach consisted of early artificial rupture of membranes, aggressive use of oxytocin and the continuous presence of a one-to-one midwife. With this approach, there was a marked decrease in the length of labor and the need for caesarean birth. Since the mid-1980s hospitals in the United States have aggressively used the first two technological interventions of the program but the third, a continuous one-on-one midwife presence, has not been adopted or advocated.

Further evidence for social support in labor was provided by Hodnett's (2000) meta-analysis, which examined all of the randomized and controlled trials of continuous woman-to-woman (midwives, doulas, nurses, women) support of healthy laboring women. Three of the fourteen studies reported by Breat et al. (1992) discussed the impact of the continuous presence of a midwife. Hemminki et al. (1990) reported a study of the use of midwifery students to provide social support during labor. The benefits of the continuous support were impressive for the obstetrical outcomes observed. These benefits included fewer operative deliveries, fewer cesarean sections, less need for analgesia and anesthesia. In addition, there were fewer low apgar scores, fewer women with negative

views of their childbirth experience and a greater maternal satisfaction. The women also expressed a greater sense of control with the childbirth experience, and fewer problems with coping during the experience.

### Discussion about the Review

The review of literature demonstrated a clear theoretical, philosophical, physiological, and empirical basis for being with a woman as a central concept of midwifery care. An antecedent to this concept was a willing and desired relationship between the midwife and the woman where the midwife acted as a companion and guide. The two most representative attributes of being with a woman were providing available human presence and social support. These attributes met the woman's perceived emotional, physical, spiritual, and psychological needs. From a physiological perspective, presence decreased anxiety, pain, and fear that contributed to a shorter labor and better birth experience.

The qualitative research review demonstrated that women continue to value and desire the attributes of being with a woman. Qualitative and quantitative studies documented the beneficial maternal/neonatal outcomes of being with a woman. The review of the literature regarding the concept being with a woman supported the clear need to retain it as a part of midwifery practice. The paucity of research about midwifery care from the midwife's perspective demonstrated the need for exploratory research about the components of being with a woman.



## Poetry

Poetry is a unique medium for human expression. It allows thoughts and feelings about everyday human experiences to escape from unconscious workings of the mind. Poetry is the raw emotion of inner truth expressed via language in a common cultural medium (Hunter, 2000). Poetry has been used within the nursing profession to increase understanding of the importance of arts and humanities and to increase understanding of the patient's and the nurse's lived experience. Poetry has been used in nursing education, nursing theory, and, on occasion, nursing research. Nurses have also used poetry as a therapeutic modality in client care. Hunter (2002a) concluded that the inclusion of poetry provides nursing with the opportunity to gain new meaning and understanding about the profession and the nurse-client relationship. The common thread that has wound through both nursing and poetry has been the phenomena of lived human experience. Whether it was read or written, from the perspective of the student, patient, family, observer, or nurse, poetry has represented humanity and the uniqueness of each human experience.

### *Definitions*

Barnhart (1953) defined poetry as “the art of rhythmical composition, written or spoken, for exciting pleasure by beautiful, imaginative or elevated thoughts ...poetic qualities however manifested ...a poetic spirit of feeling...and ...a literary work in metrical form: verse...” (p. 935). A poem was defined as a composition in verse, characterized by “...artistic construction and imaginative or elevated thought...” and “...great beauty of language or thought...” (Barnhart, 1953, p. 935). *The Random House Webster's College Dictionary* (2000) definitions of poem and poetry remained true to the older definitions with two exceptions. First, over time the definitions of poetry and poem

have become less specific, reflecting the fact that contemporary poetry is no longer required to follow traditional schools of literary thought using specific metrical recipes. In other words, a poem need not be in verse. Secondly, a poem may reflect the fact that rhythm and heightened language are used to “express an imaginative interpretation of the subject” (*The Random House Webster’s College Dictionary*, 2000, p. 1021). The music or rhythm of the poem comes from the poet and is interpreted or re-interpreted by the reader.

Two important ingredients of a poem were that it had a rhythm or tune, though it did not necessarily rhyme, and that it was evocative. Evocative means that, through imagination, artistry, and interpretation, a poem elicited memories or feelings about an experience or event. These societal definitions of poetry differed somewhat from those of experts in the literary field of poetry (Dias, 1987; Drew, 1933; Duke & Jacobsen, 1983; Raffel, 1984; Rosenthal, 1974; Selnicourt, 1952).

Raffel (1984) stated “poetry is a disciplined, compact verbal utterance, in some more or less musical mode, dealing with aspects of internal or external reality in some meaningful way” (p. 1). Paradoxically, Raffel then stated that the meaning of poetry was more easily defined by demonstration, i.e. the poetry itself, than the definition.

Dias (1987) and Selincourt (1952) believed it impossible to provide a concrete definition for poetry and preferred instead to emphasize the essence of poetry. Selincourt (1952) stated, “poetry always means more than the actual words; but to catch the meaning, one must listen with the inward ear” (p. 17). In other words, one knows it is poetry only in the reading by a particular reader. This means that even if poetry were definable, the dictionary meaning would not be the same as the effective meaning. The

effective elevated metaphoric, abstract language that is common to poetry is the rationale for the inability to define it in concrete terms. Drew (1933) noted that poetry is spirit, intuition, energy, and a divine glimpse of life. These conceptual ideas about poetry do not lend themselves to concrete objective definition.

### *Poetry as Art*

Drew (1933) commented that there was no one-way to read or understand poetry despite the myriad of books written about proper poetry critique and technique. Attributes necessary for the reading of poetry were appreciation, enthusiasm, and direct contact with the poem. However, for some readers, in addition to the pleasure that comes from reading poetry, there was a further discrimination or *art* that questioned how the poem brought forth its effect upon the reader. The art looked for what was in the poem. This attribute of poetry was the premise that poetry was not a science and not a factual description but art (Dias, 1987; Drew, 1933; Rosenthal, 1974; Selincourt, 1952). In fact, Selincourt (1952) reminded us that poetry was one of the oldest forms of art second only to dance.

The traditional view of pure science is that of the gathering of factual, objective data in attempt to reflect reality. Poetry is more than the object, more than the principle, and more than the scientific fact. Selincourt (1952) called poetry the antithesis of science, and stated that, “science increases knowledge; poetry deepens and enriches the sense of life” (p. 19). Science can tell us what a thing *is*, but poetry can tell us the *ofness* of the thing itself.

Poetry provided the feeling, the magic, the evocative, and effective meaning of experience. Drew (1933) stated that poetic language did not convey facts but suggested the quality and evocative nature of the fact. Poetry was more than what met the eye: it

was the wholeness of the possible meaning. Rosenthal (1974) reminded us that art was not necessarily measured by the literalness or the hard reality of an object but by the intensity of the feeling that it evoked.

*Human Experience as the Origin of Poetry*

Another attribute of poetry was that it emerged from raw human experiences (Dias, 1987; Drew, 1933; Duke & Jacobsen, 1983; Raffel, 1984; Rosenthal, 1974; Selincourt, 1952). The poet took memories of life experiences and magnified the nuances through rich and heartfelt language to let the poem represent more than the whole of the experience.

Part of the beauty of raw experience as the basis for poetry was that it resided in experiences common to all humans across ethnicities, cultures, borders, and time. Poetry was life itself interpreted by the poet from a singular perspective at one moment in time. Poetry was not just writing about what one knows from an experience but also what one did not know they knew about the experience. The reader has the opportunity to grasp meaning as expressed by the poet or to re-interpret meaning from all the possibilities derived from his or her own perspective. Rosenthal (1974) noted that poetry was our common life and ordinary experience from politics to love, from death to private things. Poetry penetrated through time and space, memory and awareness, and associations with and feelings about these experiences.

Rosenthal (1974) believed that poetry represented natural human activities and one's awareness of them. Rosenthal stated: "Poetry is filled with memories of the physical impact of feelings and sensations" (p. 3). Rosenthal further postulated that poetry was the fullness of our life, the way we feel, our perspectives of those feelings,

and our remembered experiences of being gratified or thwarted. Poetry was founded in experiences we have had or could have.

The reader has the ability to understand and feel the poem as they interpret the experience through the written word of the poet's conscious and unconscious mind. Drew (1933) stated that the poet generated a sense of "unknown modes of being that reveals things to the mind in relationships which are hidden in normal experiences" (p. 23). Drew added that the poet took the human experience and recreated it, fusing the moral, emotional, physical, and intellectual planes of *being human* into one harmonious horizon.

### *Poetry as Metaphor*

The word metaphor originated from the Greek word *metapherein* meaning to transfer. Metaphors represent a literary phrase or symbol that was used to represent something else (Random House Webster's College Dictionary, 2000). Hirsch (1999) stated that a metaphor was a collision where energy, identities, and modes of interpretation collided. Though not specifically stated, a metaphor often represented the evocative imaginative thought, the beauty of a poem, and the elevated thoughts found in the official definitions of poetry. Metaphors provide us with the opportunity to look at something from a different perspective, using language as the creative medium.

Because poetry utilized words through metaphor it represented the color, atmosphere, and ambiance of words. Selincourt (1952) noted that poetry was music, the evocative word and metaphor. Metaphor was the part of a poem that allowed images and ideas to fuse into a single whole. Drew (1933) believed "poetry is the most complex use of language there is" (p. 67). Almost seventy years later (Hirsch, 1999) agreed saying

“Poetry evokes a language [metaphor] that moves beyond the literal and consequently, a mode of thinking that moves beyond the literal” (p 13).

Hirsch (1999) noted that reading poetry was an act of reciprocity between the reader and the writer. For reciprocity to occur there must be a fusion upon the horizon of the poem between the reader and the writer where the interpretation occurred.

## Nursing and Poetry

### *Aesthetics*

Though qualitative nursing research has most frequently concentrated on interviews as sources of data, a small but growing number of nurses are looking at more aesthetic approaches to investigational inquiry such as drawings, photography, poetry, diaries, and documents.

Nursing’s aesthetic movement had been helped by Belenky et al.’s (1986) discussion about women’s ways of knowing and Carper’s (1978) work on nurse’s ways of knowing. Belenky et al. (1986) provided rich samples of what constituted knowledge from a uniquely female perspective and broadened the awareness of aesthetics. Carper’s (1978) patterns of knowing provided the original stimulus for nursing to look beyond empirical knowledge and to embrace aesthetics (art and beauty) and personal knowledge as legitimate sources of truth.

Almost twenty years later, Silva, Sorrell, & Sorrell (1995), expanded upon Carper’s original work. They believed knowledge also incorporated the *in between*, that which was revealed through non-linear meditative thinking and *the beyond*, the concepts, which might be knowable, but not by concrete definition. These ideas were congruent

with the nature of poetry and the meaning it provided for lived experiences. Because of the similarities between poetry and the art of nursing and the central tenet of knowing, poetry appeared to be an excellent medium for enhancing nursing knowledge.

### *Nursing Literature and Poetry*

People who happened to be nurses have written poetry. However, Trautman (1971) pointed out that it was not until the early 1940s that a few poems were written by nurses about nursing, patients, or nursing phenomena. The first poem Trautman found about the nursing experience was in the 1935 *American Journal of Nursing*. Trautman postulated several reasons for the initial lack of poetry by nurses that reflected human experience or nursing experience. Until the 1960s training was technically oriented to the physical care of the patient and nursing education did not emphasize the value of abstract thinking. In addition, it was not until the early sixties that classes in communication and/or English, which included creative writing, became standard requirements in nursing education. There are many recent examples of books of poetry with nursing as the central theme, such as those by Bryner (1996) and Davis & Schafer (1995). Poetry books by or about nursing have also been centered around concepts or specific topics such as Hunter's (2000) anthology of childbirth poetry, Krysl's (1989) anthology on the concept of caring, and Bice-Stephens (1992) collection of poetry that emphasized the art of nursing and caring for patients.

### Poetry and Nursing as a Profession

Most discourse and texts about poetry and the nursing profession stressed the need for and importance of arts and humanities in nursing. Allen (1993) emphasized how

poetry reminded us that nursing was more than technology. Birx (1994) described how poetry could broaden the nursing profession by sharing esthetic knowledge, educating those outside our profession about nursing, and enhancing our personal growth as we gain insights about caring. Bryner (1996) suggested that poetry could help explain our profession, its history, the importance of nursing language, and the art of nursing. The art of nursing helped us to discover the lived experience of nursing and caring (Gehrke, 1994; Holmes & Gregory, 1998; Landsverk, 1995; Masson, 1991; Muff, 1996).

Richmond (1995) argued that poetry helped one to redefine the spirit of nursing. Munhall (1986) described the way poetry lets one look at the other meanings that were not structured scientific truth. Munhall believed this perspective allowed one to see the beauty of nursing and helped to unite nurses in their common beliefs about nursing and caring.

Numerous nurses have examined how poetry has shaped or could shape nursing theory. In the late 1980s Fulton (1987) turned narrative nursing theory written by Virginia Henderson into prose and poetry to assist in interpreting the meaning of the theory. Watson (1994) used poetry and metaphor to demonstrate eco-caring theory, while Cody (1994) and Hodnicki, Horner, & Simmons (1993) used poetry to explain concepts from Parse's (1992) nursing theory. They stated that the lived experience found in poetry helped to formulate and answer research questions germane to nursing.

The art and humanity of poetry has helped nursing to foster thinking and to understand what was meaningful for nursing. Poetry has helped the nursing profession to understand more about their feelings as caregivers and to explore ways of knowing that



were particularly relevant or appropriate to their profession. Poetry helped us to define our profession and provided a needed link to our personal and professional history.

### *Nursing Education and Poetry*

Nursing education has used poetry in two ways: reading poetry and writing poetry. Students have read and written poetry to learn about the lived experience of being a nurse or patient (Anthony, 1998; Treistman, 1986); to discover their feelings and perceptions about nursing and patients (Schuster, 1994); to learn about specific patient perspectives such as those of the elderly (Schuster, 1994; Taft, 1989; Taylor, 1985) and the new mother and newborn (Schuster, 1994). Poetry has also been used to synthesize information and evaluate learning (Peck, 1993); to test nursing knowledge (Smith, 1996); and to learn didactic nursing content. Smith (1996) presented an interesting use of poetry as a learning vehicle for nursing. Smith's work gave examples of poems used to examine student's nursing knowledge. Students were required to discover the chief complaints found in each poem, make an assessment, and write a plan based on information in the poem.

Poetry and literature in nursing education can foster critical, creative, and analytical thinking. Through poetry students learn about themselves, human experiences, clients, nursing knowledge, ways of thinking, and ways of knowing that emphasize personal and aesthetic knowing instead of empirical knowledge as defined by Carper (1978).

### *Poetry and Patient Care*

The literature confirmed that poetry could be therapeutic not just for student or practicing nurses but also for patients. In a variety of client settings, poetry has been found to be therapeutic and a way to increase communication.

Arnott (1985) used familiar poetry to draw nursing home residents into the real world and increase dialogue. Others discovered that interpreting and writing poems in group therapy allowed clients to reminisce and evoke feelings and emotions. These experiences helped to bring resolution to the participant's concerns (Edwards, 1990; Koch, 1978; Parris, 1986; Taft, 1989).

Numerous nurses have found that the writing and reading of poetry in group sessions to be beneficial for mentally ill clients (Card, 1969; Carty, 1988; Felver, 1982; Madden, 1990). Social skills and therapeutic relationships improved and support networks were fostered within the groups. Chouvardas (1996) found that examining the poetic quality, metaphor, and symbolic meaning of "schizophrenic speak" could increase therapeutic communication between the provider and individual clients.

The literature suggested two other groups of clients and their nursing specialties that might benefit from poetry. These two groups were clients in the pediatrics and hospice care settings. Strodbeck & Perez (1981) described a program that used poetry in a pediatric setting to increase therapeutic relationships between the patient and nurse and that helped both groups express emotions about illness.

Two personal stories described how poetry was helpful to dying patients and their nurses. Pfeifer (1995) eloquently described her experience of being unable to connect with a patient dying from renal failure because of racial and cultural differences. The

patient used poetry to communicate his feelings. This medium allowed her to begin to understand his personal experience of dying. Anecdotally, Schmidt (1988) discussed her belief that reading poetry was a soothing and helpful type of caring for dying and comatose patients. Interestingly, it was a poem written by one of her patients that caused her to re-evaluate her own philosophy about life and gave her the impetus to begin reading poetry to patients on the night shift.

### Nursing Research and Poetry

It was distressing that so little research had been conducted to document the benefits of poetry for the nursing profession and their clientele. The literature review showed that poetry in and of itself was a rich and diverse source of meaning. Specifically, it was a source of discovery about the lived experience and the uniqueness of each human being. It was also apparent that it was a special lens for viewing the relationships between a person and the world. Poetry as text was an untapped source of knowledge and information for the qualitative nursing researcher.

The earliest research using poetry was influential. Oiler (1983) read and reread and reflected upon 53 poems in an attempt to learn about *nursing reality*. Though not labeled as such, this study was one of the first attempts to use interpretive phenomenology and hermeneutics with poetry as text to learn about the lived experience of nursing. The analysis resulted in the development of themes about the world of nursing and the nurses need to connect and relate to patients on an emotional and personal plane,

Ironically, the next study in chronological order was the only quantitative study found using poetry (McKoy, 1984). McKoy (1984) measured well being in the elderly

before and after teaching them to read and write poetry. The findings were significant at the  $p = .05$  level for increased social interest after four weeks of poetry intervention when compared to the control group.

The literature review revealed only three qualitative studies, all hermeneutical and phenomenological, using poetry as data. Barleben (1993) studied the lived experience of homelessness for women with children. The theoretical framework used were feminist theory, holistic nursing and Watson's (1985) theory of caring. The methodology for interpreting the 14 interviews was guided by van Manen. Some of the homeless wrote poetry or responded in interviews after reading poetry about homelessness. The researcher was moved to write her own poetry about the lived experience during her research. Appropriately, the poetry generated was included as data in her research.

Cody's (1994) basic research question was based on the desire to understand the meaning of being human. Selected poems from *Leaves of Grass* by Walt Whitman (1883) were interpreted using Parse's (1992) human becoming theory. Cody's study was hermeneutical, based on Gadamerian philosophy. Cody noted main themes in Whitman's poetry such as the body and spirit as one, the relationship between self and world, the uniqueness of the individual, and the portrayal of life as *everyday* through the interpretation of the poetry.

Gilchrist (1998) used a qualitative hermeneutic semiotic design to learn more about the experience of deafness by interpreting a poem about a deaf man. Ray's (1990) interpretive method was used to develop a central theme called "echoes of meaning". Gilchrist believed that living with the poem and inner self-reflection provided a shared

experience, through the poem, of the unique meaning of deafness that could not be captured through other research methods.

### Discussion about the Poetry Review

Poetry is aesthetic, evocative and understandable across time and culture. Its use of metaphor and expressive language provides the opportunity to gain new meaning and truth about lived experiences and the nurse-patient relationships. A poem also provides a chance to look at the unique relationships between the poet, the poem, the reader, and the world by interpretation.

The nature of poetry as an art form originating in human experience lends itself to use as textual data for nursing research. The literature review demonstrated that poetry was a rich, untapped source of meaning especially suited to qualitative nursing inquiry. There was ample precedent set by qualitative nurse researchers and nurse experts for the use of aesthetics in research, though little research has been conducted with poetry as text. The profession of nursing needs to further embrace poetry as an important way of knowing about our profession and the clientele we serve and as a useful and therapeutic tool in education, communication, and relationships.

## CHAPTER 3

### METHODOLOGY

The purpose of this chapter will be to explain the overall design of this research. The first section will describe the methodology. Hermeneutical phenomenology and its scientific and philosophical underpinnings will then be presented. Next the philosophical and personal perspective that informs the study will be discussed. A description of how data was selected and collected will follow. The fourth section will describe the method chosen for analysis and how the study will be evaluated for trustworthiness and authenticity. Finally, limitations and concerns will be discussed.

#### Human Science Research

This study was conducted under the human science orientation of research that was derived from the philosophy of Wilhelm Dilthey. Dilthey (1987) believed subjective information gathered either verbally or textually from individuals presented a unique opportunity to understand the meaning of human experience. Human science emphasized the understanding and interpretation of social, historical and cognitive phenomena. van Manen (1997) described human science as that which studied a person instead of a subject, in order to understand what was meaningful to the person and how the meaning was derived. van Manen further postulated that the study of life or practice came first in human science research and that theory flows from the understanding of life's meaning.

van Manen (1997) also stated that human science research through the textual activity of reflective writing was both phenomenological and hermeneutical. It was phenomenological because the researcher sought to describe the meaning from a lived experience of human beings and it was hermeneutical because it interpreted the meaning of the written expression of the lived experience found in the text.

### *Phenomenology*

Phenomenology, the study of phenomena, became a dominant principle through the work of Edmund Husserl. The phenomenological movement came about due to the perceived inappropriate use of positivism for the study of human sciences (Cohen, 1987). Many researchers considered it impossible to quantify or objectify a human being, thus phenomenology became an avenue for the study of human beings and their experience of living.

*Husserl's Contributions.* During Husserl's lifespan (1859-1938) the philosophy went through many transformations, though numerous main descriptive psychology tenets have prevailed. First, experts in phenomenology (Cohen, 1987; Koch, 1995; Oiler, 1982; Paley, 1997) discussed Husserl's belief that it was necessary to suspend preconceived notions in order to get to the beginning of all knowledge. For this phenomenological reduction to occur it was necessary to bracket, e.g., put aside all of one's preconceptions and presuppositions concerning the world, and previously constructed theories and concepts. Cohen's (1987), historical review discussed Husserl's belief that if one purposefully bracketed past life experiences and left a clean slate it would be possible to experience the real and genuine form of the phenomena itself. Spiegelberg (1982) described a second process of Husserl's, that of intuiting, or the

discovery of the meaning of a thought that involved deep reflection or transcendental subjectivity where the pure ego or deep consciousness was able to garner the meaning of phenomenon through presuppositionless self-reflection. This reflection described a real phenomenon or occurred in the imagination or memory. A third concept from Husserl, detailed in Koch's (1996) review that was important to modern day phenomenology was the world of lived experience. Husserl called this *life world* or the lived experience. Attention should be focused upon describing every day experiences that are taken for granted. Cohen (1987) described this as our natural attitude or the world of every day experience. Koch (1996) described how a fourth belief of Husserl's, that of Cartesian duality, was an important reason for the departure of Heidegger, his student, to hermeneutical phenomenology. Nursing science has found the philosophy and method of phenomenology a useful approach for the inductive descriptive study of everyday lived experiences.

*Heidegger's Contributions.* The change in phenomenology from the epistemological *what is being*, to the ontological, *being in the world*, was derived from Heidegger, a student and critic of Husserl. Leonard (1989) described how Heidegger radicalized phenomenology by asking an ontological question: What does it mean to be a person? rather than an epistemological question: How do we know what we know? Morse (1992) described how it was necessary for Heidegger to believe that presuppositions were indeed a necessary element in one's search for meaning. Heidegger (1962) rejected the Cartesian duality claim of both objectivism and subjectivism. This rejection allowed the concept of *Dasein*, *being in the world*, to prevail. Koch (1994) described this as a view whereby the person and the world are together in unity. As such,



man must exist within the world and not be detached from it to make sense of his experience.

Koch (1995), gave credit to Heidegger for five initial beliefs. The first, *background*, (part of the hermeneutic circle) alluded to a person's history or background that was handed down via culture. The second, *preunderstanding* described common background themes such as language and traditional practices that assisted a person to understand the meaning and organization of a culture. *Co-constitution* a third belief, referred to the undeniable and indissoluble unity of person and world. Heidegger's fourth piece of the hermeneutical circle was the belief that all claims to understanding came from a pre-existing set of structures that could not be eliminated but only modified. Finally Koch discussed Heidegger's claim that one could not have a world, live in a world, (co-constitution) or have a culture, e.g. background and preunderstanding, except through acts of interpretation.

### *Hermeneutic Phenomenology*

Hermeneutics was defined by the *Random House Webster's College Dictionary* (2000) as "the art or science of interpretation" (p. 616) especially the Bible, and indeed that was where textual interpretation had its origins. Pascoe (1996) stated, "Hermes from Greek mythology, was the wing footed messenger whose purpose was to interpret what was beyond human understanding into intelligible language or prose" (p. 1309). Both Protestants and Catholics have applied hermeneutics to ambiguous biblical passages.

The theologian Johann Dannhauer first introduced the Latin word *hermeneutica* in the 17<sup>th</sup> century. Dannhauer believed that there were two basic types of science and hence two basic types of truth: logic and hermeneutics. The role of logic was to determine the

true claim of knowledge by showing how it was derived from higher rational principles, thus logical truth sought to find out if what was meant was true or not. Hermeneutics sought to discover the significance that the author attached to the signs used, regardless of the validity of what was conceived or the level of thinking. Thus, hermeneutical truth strove to discover what was meant (Grondin, 1995).

Hans Georg Gadamer, a German philosopher and student of Heidegger, moved hermeneutics away from the conscious, as a method of interpretation, and towards ordinary language as a medium for interpreting meaning in the world (Pascoe, 1996). Much of Gadamer's work was based upon the initial work from Heidegger's (1962) philosophical beliefs in *Being and Time*.

#### Hermeneutic Philosophy

The extensive work of Gadamer was credited for developing the foundation of hermeneutics into today's contemporary hermeneutical philosophy that emphasized the human experience of understanding and interpretation (Thompson, 1990). Since Thompson's extensive review on hermeneutics many other nurses have espoused philosophical hermeneutics in their writing or research (Allen & Jensen; 1990; Annells, 1996; Cody, 1994; Draper, 1996; Koch, 1994, 1995, 1996; Mitchell, 1994; Pascoe, 1996; Walsh, 1996, 1997).

Pascoe (1996) believed that Gadamer's hermeneutical philosophy was an excellent framework for generating nursing knowledge for two reasons. First it was holistic, keeping body and mind together and the object and subject together. Second, because the nurse was an active participant who recognized the interconnectedness of the

research process between the patient and the researcher and the senses and reality.

Mitchell (1994) summarized hermeneutics as the process that “represents the movement of insight and discovery as researchers come to understand the familiar in a new way” (p. 225). The key philosophical tenets of Gadamer that will be discussed are preunderstanding, fusion horizon, the hermeneutic circle, and the emphasis of written language as a universal mode for interpretation (Annells, 1996; Koch, 1996; Pascoe, 1996). Precisely, because of Gadamer’s philosophy there was a tendency for many of the tenets to intermingle.

### Gadamer’s Tenets

#### *Preunderstanding*

Preunderstanding was Gadamer’s belief that our past experiences, and the past itself shaped our prejudices and prejudgments and influenced our interpretation of events. Grondin (1994) added that Gadamer had been able to explain how the historicity of being was all-important to understanding our historically situated consciousness. The human sciences then had the task of examining the expression of consciousness itself. Therefore prejudices and prejudgments, i.e. preconceived ideas and views, were openly embraced by Gadamerian hermeneutics as part of a universal understanding not to be bracketed or reduced as in Husserlian phenomenology (Annells, 1996; Koch, 1996). In Weinsheimer (1991) the importance of knowing one’s prejudices prior to interpretation was stressed as a way of bringing text to truth. Koch (1996) further defined prejudice as value positions that were necessary to our understanding during the nursing research process. Walsh (1996) described how one’s very understanding of the meaning of being a nurse would

effect the nurse's interaction and judgment of how understanding was revealed through text or narrative. Hermeneutical philosophers acknowledged our rich historical past and cultural traditions and emphasized that our knowledge was very much an intuitive or tacit part of our experiences. Followers of Gadamer believed it was impossible to distance one's self from our prior knowledge and understanding.

### *The Hermeneutic Circle*

Grondin (1994) discussed Gadamer's view of the hermeneutic circle, a term borrowed from Heidegger. The circle was universal because motivations and prior biases influenced all understanding. Hoy (1997) reaffirmed Heidegger's and Gadamer's recognition of the phenomenon as "what is being interpreted is the interpretation itself" (p. 113). Hoy then described the necessity of the to and fro of human understanding as one attempted to find meaning in an experience and to use interpretation to make sense of the thing ourselves. Koch (1996) added that the aim of the hermeneutical circle was not to understand truth finally, but only differently. Part of seeing the truth in a hermeneutical circle was the realization that the process of interpretation was dynamic and not static: what is now shaped what will be (Allen & Jensen, 1990). Again, the concept of the circle as metaphor described the continual movement, not the end or finality of an interpretive process: working back and forth from self to event (text) to event to self, to interpret meaning. Because of the concept of the hermeneutical circle, the nursing researcher became part of the research process as an active participant. Walsh (1996) gave an example of the hermeneutic circle from his research that involved interviewing psychiatric nurses about their experience of nurse-patient encounters. The nurses were unable to stay with just the encounter. Instead innumerable details, pieces of history and

bits of information were used to help describe the encounter itself. Walsh stated, “they were moving between ‘the whole’ of their relationship with the patient to ‘the part’ of the encounter” (p. 235).

### *Fusion Horizon*

Gadamer (1989) wrote “In view of the experience that we have of another object both things change - our knowledge and it’s object” (p. 354) and “to understand a text means to apply it to ourselves” (p. 398). Weinsheimer (1991) described this fusion of horizon as a reciprocal transference where the interpreters were altered not through a new piece of knowledge but by interpretive self-realization. Self-reflection was a vital aspect of the fusion process. The hermeneutical inquiry occurred through the interpreter’s fusion of inquiry with the text. Part of the fusion therefore, included the interpreter’s prejudices and the preconceived knowledge of his present and historical personal horizon (Annells, 1996; Walsh, 1996). Weinsheimer (1991) interpreted the fusion horizon as a process in which the text and the interpreter asked questions of each other in such a manner that the interpreter’s horizon could be broadened.

### *Written Language as a Universal Mode of Interpretation*

Gadamer (1989) wrote, “Our inquiry is guided by the basic idea that language is a medium where I and world meet or, rather, manifest their original belonging together.... Being that can be understood is language” (p. 474). He further described how when verbal translations were written, the unique opportunity for co-existence occurred between the past and present. Text allowed the interpreter to move back and forth. Gadamer said that the ... “written text presents the real hermeneutical task. Writing is self-alienation. Overcoming it and reading the text is thus the highest task of

understanding” (p. 390). “In writing, language gains its true ideality, for in encountering a written tradition understanding consciousness acquires its full sovereignty” (p. 391).

Weinsheimer (1991) gave a depiction of Gadamer’s belief that language was fundamental to our being in the world and our interpretation of it. Weinsheimer stated

The philosophical task is to discern what always happens—that is what is common to all modes of understanding; and what is common to them is that even the most objective interpretation portrays when it is written by registering the impact of then current, social, intellectual, and political forces (p. 36).

The special claim of language was that it was universal. It was universal because it gave expression to all reasoning and all thoughts (Gadamer, 1989; Grondin, 1994).

From a research perspective, Walsh (1996) stated that pivotal understanding was achieved when the history, language and traditions of nursing met with the participants of the research.

### Method

The foundation for van Manen’s (1997) human science research method consisted of four-research activities specific to data analysis. These did not occur in a linear or sequential manner but instead the researcher moved in a continual back and forth fashion through the activities with writing as the method. These activities are as follows:

Turning to a phenomenon which seriously interests us and commits us to the world; investigating experience as we live it rather than as we conceptualize it; reflecting on the essential themes, which characterize the phenomenon; describing the phenomenon through the art of writing and rewriting (p. 30).

Much like the hermeneutical circle these activities were parts of the whole, which were woven into a pattern by the researcher's investigation of a phenomenon of interest. The four activities in van Manen's method were used to thematically interpret the poetry as text in order to discover the meaning of the lived experience of midwives as they were with women during childbirth. The researcher asked the following question of the text: What is the meaning of being with a woman during childbirth for the midwife as she lives the experience?

*Turning to the Phenomenon of Interest*

van Mannen (1997) stated that phenomenological research "is always a project of someone: a real person who in the context of a particular individual, social and historical life circumstances, sets out to make sense of a certain aspect of human existence" (p. 31). In this research, the meaning of being with a woman during childbirth for midwives was the phenomenon of interest. As described in van Manen's first research activity my interest in and commitment to the phenomenon of inquiry has been based upon my own definition of who I am within my culture and society: a midwife, nurse, mother, poet, and researcher. van Manen (1997) called this the researcher's orientation to the phenomenon. Here and throughout the text I have presented my assumptions and preunderstandings that influenced and directed the nature of my inquiry. I am deeply concerned about the medicalization of childbirth, and the midwife's inability to routinely provide a major tenant in midwifery care: the ability to be with a woman during childbirth. I believe that learning more about the phenomenon from the midwife's perspective will assist me in addressing the above concerns.

*Poetic Commitment.* Birth is a right of passage and considered to be a major life event in our culture. Because of this, there existed the capability for and the possibility of experiencing any one or more of all the possible emotions that could exist during childbirth. These emotions and feelings may be so intense that they are difficult to express in everyday conversation. Poetry with its use of metaphor and freedom from a conventional style is an ideal medium for expressing these deep feelings. van Manen (1997) said, “Poetry allows the expression of the most intense feelings in the most intense form” (p. 70), and “A poet can sometimes give linguistic expression to some aspect of human experience that cannot be paraphrased without losing a sense of the vivid truthfulness that the lines of the poem are somehow able to communicate”(p. 71). For those who write poetry, the verse becomes a written reflection of the lived experience. Poetry written about childbirth and midwifery was used to investigate the lived experience of the meaning of being with a woman.

Hunter (2000) stated “Poetry is a unique medium of expression. It allows everyday thoughts and feelings that could never be expressed in everyday language to escape from the inner workings of our minds. Perhaps it is the very inherent rhythm of both poetry and birth that allows the truth to be revealed in written word” (p. 1). I believed that using poems as data would help me to find the essential qualities of being with woman from the midwife’s perspective. Through linguistic description, I hoped to capture the essential essences of being with a woman as the poetry was interpreted through reflective writing.

*Philosophical Commitment.* The commitment I brought to the study of phenomenon, a midwife’s experience of being with women, was consistent with Gadamer's (1989) and



Heidegger's (1962) philosophical stances concerning preunderstanding and forestructure. Preunderstanding was Gadamer's belief that our past experiences, the past itself, shaped our prejudices and prejudgments and influenced our interpretation of events. Heidegger's *fore-structure* was a three-fold process that linked understanding with interpretation. *Fore-having*, the practical familiarity brought to a situation, the background of our world, which made interpretation possible. *Fore-sight* was the background of the life-world (our culture, history and social context) that provided our point of view from which we made an interpretation. *Fore-conception* involved acknowledging our background and knowing that we had some preconceived ideas and expectations of what a possible interpretation could be. Unlike Husserl, both Gadamer, (1989) and Heidegger, (1962) believed that one's historical perspective and understanding of the world as interpreted by the self, gained from living the everyday, could not be bracketed away and prevented from tainting the interpretation. Instead our understanding and interpretation of the world was acknowledged and even embraced as important to the interpretation.

My unique orientation to the phenomenon, my personal experience, views and beliefs were all essential in my formulation of the phenomenological question of inquiry: What is it like as a midwife to be with a woman during childbirth? van Manen (1997) stated that the meaning of the lived experience became hermeneutical through the reflection and interpretation of the researcher that was eventually revealed as written text. *Investigating Experience as We Live It*

The use of one's own personal experience was the second step in the investigation of the phenomena of a midwife's experience of being with women. van Manen (1997) offered a potpourri of activities that might be used for further exploration based upon the

researchers preference and type of inquiry. For the purposes of this study, personal experience and experiential descriptions from poetry written by midwives were used to investigate the phenomena of being with women. From the Gadamerian philosophical perspective I was part of the hermeneutical circle and my preunderstandings and personal experiences fused with the data through self-reflection that became writing as method.

*Personal Lived Experiences about Childbirth, Nursing and Midwifery.* From my early childhood, I knew I wanted to be a nurse. My father encouraged me instead to be an obstetrician like he was. At the time, I could not yet articulate the difference between nursing and medicine, but I remember I wanted to help and care for people in need. At the age of sixteen my father took me with him to observe a delivery. I will never forget how scary it was for me with all the blood, and the bright fluorescent lights in the delivery room. I watched the nurse as she scrubbed the woman's perineum and saw more blood as my father cut an episiotomy. Finally a very bloody screaming baby was born. The experience further influenced my decision to never be a doctor and certainly not a labor and delivery nurse.

After finishing my B.S.N., my first position was working in the newborn nursery. I loved the babies and helping the women to breast-feed. By then I was more used to blood and the medical model of childbirth. As a new graduate nurse I began rotating through labor and delivery, and postpartum and learned the role of being a *good* nurse. My unpleasant memories faded and were replaced by the satisfaction and reward of being a *good* nurse. During labor I was able to assist the women by sitting with them providing encouragement and emotional support. However, when birth became imminent my role changed from *being with* the woman, to *being for* the obstetrician. At the birth my role

was now to assist the obstetrician so that he/she could perform the delivery and to make sure the woman was prepared for the obstetrician to do the delivery. A *good* nurse was neat and efficient and timed things perfectly so everything was ready and none of the obstetrician's time was wasted waiting for the birth. A *good* nurse was considered bad if after preparing the woman for delivery and urging the woman to push the baby was not delivered quickly. If this scenario occurred, it was common for the obstetrician to pull off his/her gloves and return to the call room until the woman was ready to deliver.

After the birth, I would take the baby before the mother could hold it in order to clear its throat with a blue bulb syringe. I actually thought babies were incapable of breathing at birth without assistance. I would vigorously rub the baby's back and sides to make him/her cry loudly to clear its lungs. Next, I would scrub away all signs of its entry into the world with a bath that cleaned the infant of blood and vernix and place silver nitrate in its eyes to prevent infection. By this time, the obstetrician would have finished repairing the episiotomy and I would then proceed to clean up the mother and move her to a recovery room. Finally, the baby completely wrapped up in blankets with only puffy eyes and face showing would be placed in the mother's arms for the first time. At the time I never imagined that the experience of birth might be different than what I had experienced. I never imagined that the experience could be different for not only the woman and her family but also the provider. It never occurred to me to question my *good* nurse role nor to question the incongruence between my women centered caring during labor and my medical care during the birth.

Writing about my personal experiences as a labor and delivery nurse prompted me to reflect and to write the following poem in my journal during this research. I believe

that writing this poem has helped me to accept the guilt I felt for those years of being a  
*good* nurse, but not always being with a woman.

### The Good Delivery Nurse

Neat, with hair tightly pulled back  
 She performed her duties.  
 Sterile  
 clean  
 efficient  
 a good nurse.

The job,  
 to bring order  
 to someone else's birth.  
 Tame it.  
 Control it.  
 Set the drapes just right  
 so the blood doesn't spill on  
 the doctor.

The birth.  
 Tightly pulled back legs.  
 Don't let her scream.  
 No squirming.  
 Don't touch the drapes.  
 Hands placed in leather straps.  
 A good push  
 equals a red face  
 and subconjunctival hemorrhages  
 as proof of honor the next day.

The baby  
 cared for by a good nurse.  
 Loud cries.  
 Scrubbed pink,  
 no earthy smell of birth  
 Hibiclens the preferred perfume.  
 Eye drops in, shot given,  
 wrapped tight,  
 sterile white bundle.

One event was initially influential in my ability to understand birth as a normal process to be supported by the provider. A nurse, who had recently returned from a military tour of duty in Korea where obstetricians were few and far between, provided me with new information and exposure to experiences concerning childbirth. She described how supportive women assisted laboring women in Korea during birth and that birth was treated as a natural normal process instead of an orchestrated medical event. I observed how she did not seem concerned when women delivered in bed before the obstetrician could arrive. Instead she would calmly give the baby to its mother to hold, cover them with a blanket and wait for the afterbirth. After watching many of these births, I started reading on my own and learned more about birth and about a profession called nurse-midwifery.

I immediately found a position as a nurse in two out of hospital birth centers with certified nurse-midwives (CNMs). There, I learned even more about birth as a natural and normal process and began to learn about the midwifery model of care. The midwifery model included being supportive to the woman and her family and just being present to meet the mother's perceived needs. An immediate convert to this model of care, I enrolled in a nurse-midwifery program. Since graduating as a nurse midwife in 1987, I have followed the ACNM (1989) philosophy as I have attended women in birth and taught students the art of nurse-midwifery. Our philosophy was one that included safe, satisfying care with informed self-determination and, co-participatory decision-making for the client and the provision of physical, emotional and social support.

Memories of my lived experiences have shaped my philosophy about childbirth and my role and participation in the attendance of other peoples birth. My continued

commitment to the phenomenon of childbirth and being with a woman has been reflected in my work as a nurse-midwife for over twelve years and as an educator of nurse-midwives for ten years. My lived experiences of caring for women during childbirth have included more than 1,000 births.

*My Experiences with Poetry.* I grew to love and enjoy poetry as a small child because my parents gave me a book of poetry each year for my birthday. To this day poetry is one of my favorite types of literature for reading pleasure. My bookshelves are filled with books that include a wide range of works by different poets.

My love for poetry and my work as a midwife inspired me to edit an anthology of poetry about childbirth in 2000 called *BirthWork*. The book included over 55 poems and accompanying photography or artwork by midwives, nurses and mothers. Editing and publishing *BirthWork* during my doctoral work helped me to analyze my thoughts and feelings about poetry, childbirth and my phenomenon of interest.

#### *Experiential Descriptions from Poetry*

The van Manen (1997) method discussed the need to investigate lived experiences as they were actually lived. van Manen believed that experiential descriptions could be found in literature and poetry, both of which he considered as story. van Manen stated that a unique lens was available through these sources because value could be found in the “perceptiveness and the intuitive sensitivity of the author” (p. 70).

van Manen (1997) believed that poetry and literature, as stories, were an excellent medium for vicariously seeing and understanding lived experiences. van Manen listed seven ideas concerning the usefulness of story to the human sciences:

[a] Story provides us with possible human experiences; [b] story enables us to experience life situations, feelings emotions, and events that we would not normally experience; [c] story allows us to broaden the horizons of our normal existential landscape by creating possible worlds; [d] story tends to appeal to us, and involve us in a personal way; [e] story is an artistic device that lets us turn back to life as lived, whether fictional or real; and [f] story evokes the quality of vividness, in detailing unique and particular aspects of a life that could be my life or your life (p. 70).

As a form of story van Manen (1997) described how poetry provided a unique look at lived experiences through the language of poetic verse. For this reason he stated how common it was to find lines of poetry interspersed through out a researcher's hermeneutical writing based upon their interpretation.

### Reflection on the Essential Themes

van Manen (1997) described his third research activity specific to data analysis, the development of themes, as the starting point for learning more about a phenomenon through writing and reflection. In the initial research, this activity was found in the journaling and beginning drafts written by the researcher.

Themes assist the researcher in focusing on the experience and making sense of meanings. Three approaches were suggested by van Manen (1997) to use when interpreting text. These approaches were used to isolate thematic statements in the poetry. In the holistic approach I reflected on the fundamental meaning of each poem in its entirety in order to understand the global meaning of the text. I asked what the main theme of the whole poem was and was it about midwifery and being with a woman? In

the selective approach I reflected upon the phrases or parts of the text, which appeared to reveal themes about the meaning of the lived experience of being with a woman. Finally in the line-by-line approach I explored each line of poetry and asked how it revealed more about the meaning of the phenomena of interest.

### Description of the Phenomenon through Writing

Through self-reflection and interpretation of the poetry eventually I composed a linguistic transformation of the themes into sentences and paragraphs that revealed the essential nature of the phenomena. van Manen (1997) described how writing was the method and the object of the research process and was used to create a phenomenological text. It was through van Manen's fourth research activity, the writing and rewriting of the text, that I was able to glean the true essences of the phenomena from the data. By writing, one brings their self-reflections and collusions with the text and the phenomena to paper where it is able to speak to others. Through this process the researcher was able to present the analysis of the data in chapter four of this dissertation.

### Pilot Study

A pilot study was conducted to practice using the van Manen (1997) method. Three poems were chosen to explore the meaning of the lived experience of childbirth. The pilot study allowed me to work back and forth through the activities in the method, practice writing and rewriting my reflections and develop initial themes. At the end of the pilot study I felt assured that that phenomenology methodology and the methods of van Manen were relative to my interests particularly hermeneutic inquiry, and the use of



poetry as non-traditional data for interpretation. A further benefit was my ability to narrow the focus of my initial phenomena of interest from a large focus on the meaning of childbirth to the more specific inquiry of the meaning of being with a woman from the lived experience of midwives.

### Method of Data Selection and Collection

Poetry was collected from a variety of books and magazines. Hunter (2000) was a source for much of the poetry. Initially the Internet and bookstores were used to trace books of poetry that were about childbirth, midwifery, nursing or related topics. Each book of poems was examined to determine if any of the poetry met the two inclusion criteria. The first inclusion criterion was that a midwife must have written the poem. The second was that the poem must be about a midwife-attended childbirth or about the experience of being a midwife. Eventually 18 such poems were found that fit the criteria for inclusion in the study. A letter (Appendix A) was written to each poet or publisher requesting permission to include the poetry in my research and future manuscripts.

It was not necessary to have my study approved by the Committee on the Protection of Human Subjects at the University of San Diego, as there were no subjects. A letter was sent for filing to the Provost in charge of the committee delineating my use of text as data.

### Evaluation Criteria

While working with the text van Manen (1997) cautioned that one must be true to the process of interpretation through self-reflection, writing and rewriting in order to

ensure that the results were rich and deep. He reminded us that one must remain oriented to the phenomenon lest one end up with only a narcissistic version of one's research or writing that simply glossed over the phenomena instead of mining its' depth and essential strengths.

### Confirmability: Evaluation of the Qualitative Research Process

Confirmability was the umbrella term used by Guba & Lincoln (1989) when a researcher established that the research process had adequately demonstrated credibility, transferability and dependability. Confirmability demonstrated that there was an audit trail for both the researcher's interpretations and the methodological and philosophical decisions along the way.

### *Credibility of the Study*

Draper (1996) stated, "although competing interpretations of a given text may be equally valid, interpretation is not an arbitrary activity" (p. 48). Draper suggested that validity for hermeneutical inquiry was reflected in the fact that a valid interpretation was defensible (credible). Koch (1994) stated "credibility is enhanced when researchers describe and interpret their experience as researchers" (p. 977). Defensibility was achieved through the writing process as the researcher's interpretation was presented for others to read. The drafts of my self-reflections and the written process of thematic analysis as I wrote my interpretations of the poems documented my thoughts and reactions to the data as I went about the process of interpretation through reflection and writing. As part of the hermeneutic circle, the drafts became material for further reflection.

In the language of qualitative research, credibility related to the thickness of the interpretation of the data. The drafts, revisions and the dissertation of hermeneutical research was the written proof of the researcher's critical thinking and self-reflection that leads to his/her interpretations of the text. It was through the researcher's writing that one could see how the personal, historical and social perspectives, assumptions, and beliefs of the researcher influenced and affected an interpretation. From the drafts and journaling one could ascertain how the text was first interpreted as a whole and then in parts and back again to the whole, perhaps many times, until themes developed. For the qualitative researcher following a constructionist paradigm, the drafts demonstrated, in a written trail, how the researcher used their thoughts as the instrument as they reorganized themselves around and in the data. The drafts documented the role of researcher in interpretation of the text. Draper (1996) stated, "interpretation involves the fusion of the horizons of the interpreter and the text" (p. 50). The journal drafts provided the audit trail for the whyness of my interpretation based upon what the text brought to me and what I brought to the text. My writing reflected my biases, beliefs and assumptions and my interpretation of the text as it spoke to me. As the two fuse over time, by critical thinking and self-reflection, themes developed from the whole and the parts of the poems and according to Kahn (1993) from my own participation as an instrument in the research. Cohen, Kahn, & Steeves (2000) described how sequential drafts showed how my understanding emerged and changed over the course of inquiry and my participation as the researcher.

In order to determine if my interpretation was credible, I had my committee members read my drafts and interpretations responsible for the development of themes to

see if they were able to see my truth as a plausible explanation of the phenomenon. In addition, I had an experienced midwife assess my thematic analysis. I asked the midwife if she could see, in the written text, my interpretation and believe it? Cohen, Kahn, & Steeves, (2000) stated that opening the inquiry to method or content experts was a way to reduce bias. van Manen (1997) called the concept collaborative assistance for the researcher, and a way to test one's research among friends who were interested in strengthening the researcher's work. In this process others examined whether my written interpretations and thoughts were an expression of the possible reality of a lived experience (Richardson, 2000).

### *Transferability*

The concept of transferability originated with Guba & Lincoln (1989) as a criterion to establish the similarity between the text that was being interpreted and the interpretation or truth from the researcher. Draper (1996) stated, "interpretation involves description of the text" (p. 49). The criterion of transferability must be left to those who read and interpret this dissertation. To ensure that the readers were able to make this judgment all poetry used in this dissertation were included in Appendix B.

### *Dependability*

Guba & Lincoln (1989) stated that a dependable study was one that could show in detail how the process of the study occurred. Again much like the hermeneutical circle, this criterion was found in the research study. If the reader could understand how I came to the decisions about the "theoretical, methodological and analytic choices throughout the study" (Koch, 1994, p. 978) and how my preunderstandings and assumptions influenced the interpretations, dependability was present. My dissertation will

demonstrate how the interpretation occurred, what I decided was relevant and why, and its thickness in relation to the amount of time spent on reflection and immersion in the data. Cohen et al. (2000) described this phenomenon as rigor, a process that ensured that my decisions were thoughtful and well examined. Denzin & Lincoln (2000) concurred that writing and journaling as method demonstrated how understanding was produced, not reproduced, as I interacted with the text.

## CHAPTER 4

### FINDINGS OF THE STUDY

The purpose of this interpretive phenomenological analysis was to discover the lived experiences of midwives being with women as they attended women during childbirth. The data for the analysis was collected from 18 poems written by midwives. The specific poems either were chosen for analysis because they reflected a midwife's thoughts on being a midwife or described the experience of the midwife as she attended a woman during childbirth. This chapter will present the essential themes formulated from the analysis of poetry used as data for the study. The themes are supported by exemplars of the poetry typed in italics and threaded throughout the findings. The interpretive phenomenological analysis found three major themes, (a) *experienced guidance*, (b) *spiritual connections*, and (c) *partners in birth*, with sub themes that form the basis of the findings of this study about being with women. The themes and sub themes represent either an action that was required of the midwife and/or a specific belief about the childbirth process and being a

#### Midwifery Knowledge

##### *Ways of Knowing*

It was discovered through the interpretation of the poetry that it was necessary for a midwife to possess certain types of knowing (midwifery knowledge) in order to believe

in and practice the essential themes of being with women during childbirth. Based upon my reflection, interpretation, and writing about the data I discovered that the themes were interpretable based upon the larger lens of midwifery knowledge. Ways of knowing were important because the midwife's knowledge helped to shape her lived experiences of being a midwife. The lived experience of being a midwife for a woman during childbirth found in the poetry in turn shaped the foundations of three basic types of midwifery knowledge that emerged from interpretation of the essential themes to complement the phenomenon of being with women. The three types of midwifery knowing were *self-knowing*, *grounded knowing*, and *informed knowing*. The ways of knowing represented overriding ideas that supported the themes found in the analysis. There was considerable overlapping of the themes and sub themes among each type of knowing. Self- knowledge sets the stage for the midwife's actions and belief's that occurred synergistically through grounded and informed knowledge.

### *Self-Knowing*

Self-knowing for the midwife was a collection of beliefs that shaped her ideas, views and thoughts about what she believed to be true about the birth experience and being a midwife. The midwife held certain ideology of personal beliefs in order to practice the phenomenon of being with women. The midwife's self-knowledge was derived from a combination of grounded and informed knowledge and her general worldview and the philosophy that she had developed concerning birth, midwifery and women. Self-knowing was the midwife's belief in what she knew, knowing what she believed and acting upon those beliefs. Themes and sub themes supporting the concept of

self-knowing that were formulated from the poetry included embodied power, spiritual connections and birth as a special experience.

### *Grounded-Knowing*

Grounded knowing was the knowledge the midwife had gained from her personal lived experiences of attending women during labor and birth and, if applicable, through her own birth experience(s). The midwife knew that certain facts were the truth because she had seen or experienced the fact itself as it emerged through the lived experience of attending births and being a midwife. Themes and sub themes that supported this type of midwifery knowledge were essential to being with women. The identified themes were experienced guidance, spiritual connections, and partners in birth.

### *Informed Knowing*

Informed knowing was knowledge that the midwife had learned as the apparent truth from a respected source. The midwife learned informed knowledge from attendance in professional midwifery educational training, through on-going professional education or from some other respected person or source. Informed knowledge was first learned from a spoken or written source, not experientially. The themes and sub-themes that supported informed midwifery knowledge were experienced guidance, succoring connections and partners in birth.

Throughout the analysis, the components of midwifery knowledge derived from the poetry will be interwoven with the themes and sub themes of being with women. Additionally the sub themes will be delineated as a midwifery action, either a midwifery belief or both. Italics delineate the poetic exemplars in the textual of the analysis.



## Essential Themes

### *Experienced Guidance*

Experienced guidance was the most salient theme discovered upon reflection with the poetry. It was the art and act of guiding the woman through the labor and birth process by the midwife. The sub themes were: (a) providing safety and protection, (b) embodied power, (c) reading the clues, and (d) handwork. Experienced guidance was for the most part an action-oriented theme of being with women. The midwife practiced experienced guidance by either doing something, *the midwife moved her hands quickly* or doing nothing *I sit near, I watch*. The midwife used her beliefs that were derived from self-knowing to assist her in providing experienced guidance. In order to be an experienced guide the midwife must have possessed the experience, the competence, and the wisdom from both grounded and informed midwifery knowledge. The midwife was able to guide the woman in labor because she knows the experience so well from both her informed knowing and her grounded knowing. Experienced guidance was knowing what to do, *I spin a safe place for her*, or not do, *knowing when to be silent*, how to do it, *precisely balancing pressure and release* and when it needed to be done *your baby needs you now India*.

Experienced guidance included grounded knowledge because the woman had shared and participated in many birth experiences, *experienced midwife's hands, where baby upon baby landed* and/or because of her personal birth experience(s), *I remember my own birth*. Because of the many lived experiences of being with woman during childbirth the midwife could use her knowledge about the unique aspects, and nuances of labor, *labor grips her in hands of steel*, how women responded emotionally to labor, *she*

*sinks into herself, loose in her body, and birth, she reached down, drawing her daughter to her breast, laughing, shouting, crying all the emotions of birth, to care for women.*

The midwife's informed knowledge, *how to do pelvic exams, how to diagnose and prescribe*, was also an important aspect of the themes of experienced guidance.

Informed knowledge was important data that the midwife was able to use in the provision of care during childbirth.

Experienced guidance required a repertoire of expert skills and techniques based upon informed and grounded midwifery knowledge to ensure a safe and satisfying birth experience. To practice experienced guidance the midwife had to be competent in the use of her very self as an instrument of knowledge. In order for the midwife's knowledge and actions to be useful the midwife must be present, *because I have a gift, the gift of presence* during the childbirth experience. Through observation, *tears slip past her eyes, voice, over and over she chanted*, and touch, *soft on her arm* and listening, *moans become cries*, the midwife used her knowledge to determine whether guidance was needed, i.e. the midwife must do something, or whether there was nothing to do. The four sub themes below exemplify specific types of experienced guidance that the midwife practiced while she was with a woman during childbirth.

*Providing Safety and Protection.* Part of experienced guidance was knowing how and when to protect women from danger and harm during the birth experience. Protection was vital during labor and birth for two reasons. First, women were emotionally and physically vulnerable during the birth process because *those in her care are vulnerable*. Second, there were inherent dangers in the birth process that the midwife must be knowledgeable about and on guard for to ensure safety for mother and baby *in the dark*

*that morning your mother bled.* The midwife could envision providing protection and safety as a proactive measure. The midwife's informed and grounded knowledge and skills of experienced guidance were used to prevent dangerous or unsafe events from occurring in the first place because she was present *I stand over her offering protection.* The midwife also knew what was happening to the mother, and what was occurring with the labor, and what the mother was experiencing emotionally during her labor and the birth process *a quick review Ruptured membranes? Week's gestation? Primagravida, nervous, frightened.* This knowledge was used to guide the midwife's action in her provision of safe care to the mother and newborn. The midwife must be knowledgeable and competent in her ability to handle unforeseen or unavoidable emergencies such as a maternal hemorrhage or a prolapsed umbilical cord, *keeping vigil knowing when to act swiftly, protecting life.*

*Embodied Power.* In order to provide experienced guidance the midwife must have had certain beliefs about women during childbirth that were formulated through her self knowing. The midwife believed that women have and could successfully give birth, *being at the woman's side who gathers from in her self the power to bear this new person into the light.* The midwife believed that a woman's body, mind and spirit were capable of birth. Through self-knowledge the midwife knew the power of women, *a primal image majestic in her strength.* The midwife knew what women could do during childbirth through her past experiences that developed her grounded knowledge.

*she brings her knees back, pulling with the power of labor in her arms  
she bears down*

The midwife knew and believed in the power, strength and knowledge a woman consciously brought to her own labor and birth;

*This woman, the round circles of her body  
All her forces concentrating  
On the work of this birth*

In addition, the midwife knew that women had an unconscious, historical knowing, *feeling the power of my own body doing what women's powerful bodies have always done*, that allowed them to trust their body to do the work of birth because that was how it had always been. The midwife used her presence and assistance to encourage women to give birth with the power and resources of their own bodies.

The midwife's belief in the laboring woman's embodied power allowed her to do all that she could to assist and support this phenomenon. The midwife's thought being: *I remember in my cells the wisdom and power of women's bodies*. Commonly, the midwife would use her voice and hands as instruments of herself for this purpose. She inspired power in the woman by telling her how well she was doing *You're almost there, You're doing so beautifully*, or with a simple gesture of her hand, *soft on her arm for comfort and confidence*. The midwife actively enhanced the woman's feeling of power through the use of powerful messages about her own strength: *you are so strong*. Simple words of encouragement that reinforced a woman's belief in herself: *you can do this and believing it* was also another way that the midwife provided experienced guidance. The midwife understood the historicity of birth and midwifery presence, *I remember that women have always birthed women*. The midwife used the historical reminder of women who had labored before as a form of encouragement to inspire confidence and strength in a woman's own power, *there's a woman in the mountain laboring, there's a woman in the ocean laboring, there's a woman in the jungle laboring and you can labor too*.

*Reading the Clues.* The *reading the clues* sub theme described the delicate balance a midwife had to have while being with women so that she knew when to intervene and assist the woman through the birth process and when to simply do nothing. Ironically, the dichotomy could not be separated, as it was a continuous dynamic process of being present and being with the woman that dictated what was done or not done to provide the experienced guidance of either doing nothing or something. The midwife used her grounded and informed knowledge to read the clues during childbirth. The midwife was able to read the clues correctly because through self-knowledge she believed that each birth experience was unique. If the midwife did not have this belief there would be nothing to interpret. In other words, if all birth experiences were the same, without variation, the midwife's presence as an experienced guide would be superfluous.

Clue reading required that the midwife, as an experienced guide, be competent and knowledgeable about the labor and birth process, *all is well, progressing nicely; we shall see this baby by noon*. Through the act of reading clues correctly the midwife knew how labor was progressing, *nagging pain, low in the belly starts to rise and fall in patterns faster, stronger* and how the woman was responding to labor, *I know that you are frightened*. Based on the midwife's interpretation of the clues she would decide to either do something *I will hold your hands and cry with you*, or nothing, *knowing when to be silent*, to assist the woman in childbirth. In order for the midwife to know that nothing needed to be done she had to be present, watchful, observant, *I sit near, I watch* and she had to know labor; *labor starts with nagging pain, insistent, localized low in the belly*. For the midwife to decide that she needed to do nothing required active participation on her part, *I was up all night with women who needed me*, to observe the woman's

responses to labor, *loose in her body*, and the progress of labor: *labor strikes faster, harder*. The eyes, ears, and intuitive senses of the midwife were used to know how labor was progressing and how the woman was responding to the process. Because the midwife was part of the lived experience of childbirth she was able to interpret the clues correctly.

*Handwork. Hands*, these hands, my hands, a midwife's hands *had a symbolic meaning for midwifery. The midwife's hands were one part of a trilogy of tangible circles present at the culmination of birth that represented the spiritual cycle of life and death. The three actual circles were the midwife's hands that encircled the vagina as she assists in the birth, our hands on the emerging circle, the vagina that became a large circle to accommodate the coming head, and the baby's round head, the disc of dark hair becomes the crown of life, as it was born through the rounded vagina and into hands of the midwife. Through experienced guidance the midwife's hands ensured that the circle and mystery of life were successful: the cycle repeats itself and the mystery remains. The midwife's experienced hands were the physical bridge that guided the newborn between before life and present life, teetering long between the blessed worlds, and between life and death as new life approaches, always in company with the specter of death.*

The midwife's hands were the most conspicuous and important physical manifestation of self as an instrument of experienced guidance for the birth experience.

*My hands  
have measured and timed  
examined, supported  
comforted, held...  
have touched new life  
have guided and welcomed it  
into the world*

Handwork was using grounded and informed knowledge to actively guide and assist a woman during the childbirth experience, *our hands working with her*. Part of experienced guidance through handwork was knowing where and when to touch a woman and exactly how much touch to use. During labor, the midwife used her hands to provide comfort, *soft on her arm*, and reassurance, *I will hold your hands*. The midwife also used her hands to provide pain relief, *strong on her tailbone*, *counter pressure to the pain*.

The midwife was usually the first person to actually touch the newborn as she assisted in the woman's birth *I hold out my hands and touch the warm moist head*. She used her hands in the final moments of labor to provide support to the perineum and make sure the baby's head was born slowly and gently. Through informed and grounded knowledge the competent actions of the midwife, *adept, sensing precisely balancing pressure and release*, helped to prevent the mother's perineum from tearing, and ensured a safe, *to safe guard her entrance*, and gentle, *love's touch...in the palm of her hand*, birth for the newborn. The midwife's hands in the final moments assisted, *midwives hands working sure, guiding you, rotating you into the world*, the newborn into its new world.

In emergency situations the midwife had to be able to think and act quickly, *the midwife moved her hands quickly*. The midwife used her grounded knowledge and informed knowledge to act competently in emergencies and knew how and when to use her hands. For instance a midwife used her hands to stimulate a unresponsive baby to breath by rubbing it with a warm cloth on its back and extremities, *there limp in my hands, needed rubs and jump starts*. If manual stimulation and oxygen were not

successful, *as trembling hands work to hold, to touch, & disturb you into life*, then the midwife had to begin CPR, *moved beat upon beat towards your heart*. If the midwife discovered a prolapsed cord she quickly inserted her hand and kept the baby's head from pressing on the cord. During a maternal hemorrhage,

*through her a red river surged and flowed...  
spilled and saturated the bedding beneath her  
flooded the floor in bloody, uncountable drops,*

the midwife was forced to place her hand inside the vagina to provide compression to the uterus.

### *Spiritual Connections*

Spiritual connections was an essential theme that first appeared through the spiritual nature of many words found in the poetry such as: souls, spirit, miracles, prayer, and God. Reflection upon the poetry revealed three sub themes of spiritual connections (a) pre-ordained connections, (b) historical connections, and, (c) comforting (succoring) connections. Spiritual connections were a combination of belief oriented and action oriented knowledge that guided the midwife while she was being with women.

As apart of self- knowledge, the midwife understood that she was meant to be a midwife, before it became a conscious decision on her part. *I have known the emotional work since before I was born*. The midwife knew that it was her special preordained destiny, *a part of life's plan*, to be with women in childbirth. As part of the midwife's ideology, her belief was that she was meant to work in the profession of midwifery; *we have always done this*, and were particularly suited to the work of midwifery.



The midwife's worldview of self-knowledge allowed her to recognize through a historical perspective, *history is only our conscious memory* that women have cared for birthing women since the beginning of time, *this work we have done all the length of history*. Through her self-knowledge, *I remember in my cells*, the midwife was aware that historically women have always been able to give birth, *women's bodies knowing how to give birth*. The midwife also acknowledged how history has played a rich and significant part in the development of her self-knowledge belief system concerning the sanctity of birth, *it is a sacred mystery ancient & ever blessed*, and the midwife's role, *it is a covenant sealed upon the midwives soul*. The midwife understood through historical consciousness that women knew how to birth, that birth was a normal process, and women had historically guided them in this process.

Because the midwife believed in a spiritual source of power that was able to work through her, she actively sought assistance from that source in times of need, *without words she called that other source*. In addition, the midwife recognized that there was more to a successful and safe birth experience, a *prayer for safe passage*, than the midwife's own skills and competence. Though the midwife used her knowledge that she had learned from both her own experiences (grounded knowledge) and that of others (informed knowledge) to guide her actions, *our hands know this work*, she also realized through self-knowledge that there was an imperceptible part of labor and birth that she ultimately could not control. Through self-knowledge, the woman believed that there was something greater than herself that had power in the universe. The midwife respected this source of spirituality and called upon it to work through her as she routinely practiced her profession and in times of great need, or emergencies.

*Preordained Connections.* Entering the profession of midwifery could be likened to that of a spiritual calling, *a calling it's called*. The midwife knew that she had been chosen to become a midwife, *it found me, God gave me a gift*, even though at first she might not have been sure exactly what kind of gift she had been given: *some without even a clear understanding why*.

However, when a person did listen to her inner spiritual source, *the path lies before me* and accepted the preordained calling to become a midwife, she did so because of the personal beliefs that shaped her self-knowledge and her ideas about how birth could be experienced, *laughing shouting, crying- all the emotions of birth*, and how she, as a midwife, could honor birth as a normal process, *to help a sister bring forth a child in as loving and gentle way as I know how*. A midwife accepted the call and became a midwife because she knew she could make a difference for women and their families in the childbirth experience, *I want to be a midwife to help change the way babies are born*. Another reason for accepting the spiritual call was the midwife's own belief in, need for, and connection to spirituality: *reach up to the sky, unite with the source*. With each birth the midwife was aware that she was connected to her universal spiritual source: *to touch the face of God in the only way I know how while bound to this earth*.

When a midwife accepted her calling she realized that she would have a job that was mentally and physically taxing and that it required enormous amounts of personal investment and energy:

*When it was over, I would pack up with my helpers,  
Go for breakfast. I needed potatoes and bread  
Something of the earth and solid ground,  
Something to remind me of just who I was really,  
Untitled, unknown, a worker –in-service.*

One of the primary reasons that being with a woman during childbirth was so exhaustive and such hard work, *I am tired, I am so tired*, was because it required heart work: *you know in your core how to care...it is this that you give, it is this that you share*. Being a midwife was a call from the heart, *for out of the heart, a midwife emerges*, and a passion for midwifery work that arose from an inner source *there was this need, or this ache or this something that pushed us forward*. In order to fulfill her purpose, the midwife accepted the inherent unpredictability and difficulties of her profession:

*the calling that causes us to leave home,  
and hearth, and family and friends, and  
many denounce comfortable livelihoods,  
Secure in our positions;  
to experience fear, and adversity, and feelings  
of inadequacy*

A person who accepted the call to become a midwife and spend hours being with women as they labored and gave birth did so because they had chosen to do so. The midwife understood that the rewards of her profession would not be the more frequently sought after tangible work related rewards. She did not become a midwife *for power, for wealth or for fame*. Instead one reward the midwife received was a spiritual renewal and connection, *the smell, the incredible smell of birth, something that reminds me there is always spring*. Another reward was the knowledge that she had safeguarded one more birth experience and one more woman through her experienced guidance and care.

*To be able in the end, to fill the need, soothe  
The ache, and live on purpose.  
For, I myself, would rather be at a birth  
Than to eat or sleep.*

*Historical Connections.* Midwifery was an ancient profession; *this work is as old as the salt in our blood.* There was a historical essence of spiritual sources from midwives in the past *their spirits stand by us in the birth room* that worked through midwives in the present *lending their skills, power and courage to the work of our hands.* The historicity arose from the fact that, as a profession, midwives had always been by women's sides during labor and birth since the beginning of time: *women have always birthed with women.* Midwives, through their self-knowledge, were very aware of and took pride in the fact that their profession had a lengthy history of being with women:

*This work we have done all the length of history  
We were there in every place, in every language*

*Doing this work back through all the days and nights and  
Centuries of history*

*And than further back.*

With this historical self knowing of midwifery, *our souls remember*, also came the understanding that birth was a normal process, *I was coming out all by myself*, and that women knew how to birth, *the child my daughter bears...to the world outside the womb.*

*Succoring Connections.* Succoring connections was both a belief and an action sub theme. The midwife knew that there was a part of labor and birth that was controlled by forces other than her own *to soon it was for you to come... in the dark of that morning your mother bled.* The midwife also believed that a spiritual source worked through her and guided her safely in her work. The midwife was not afraid of her need for a spiritual relationship as part of her midwifery work, *oh God I learned to pray*, and felt in tune with her belief in spirituality and childbirth:

*the awesome and extreme connection  
Between woman & child*

*& the work of birth, the unrelenting spirit  
that charges each to enter  
the ancient caverns of wisdom  
& faith.*

After a successful birth experience the midwife thanked her spiritual source for guiding her actions appropriately *a prayer of gratitude* and also for renewing and substantiating her worldview (self-knowledge) that birth was a normal process:

*A prayer of renewal,  
A prayer of life everlasting  
Life, Love and Hope restored.*

Though the work of guiding women through childbirth was almost always rewarding and usually ended in a wonderful miraculous birth, *the welcome wail which signaled life*, there was always the possibility of a complication or even death: *as new life approached always in company of the specter of Death*. It was this very inescapable dimension of childbirth that caused the midwife to ask for help, *a prayer for safe passage*, in an effort to ward off those things she could not control and to ask for guidance from her spiritual source: *a prayer for wisdom, a prayer for guidance*.

Even though the midwife's worldview was that birth was a normal event she had the ability and competence to manage complications and emergencies if the need arose. In emergency situations the midwife used her experienced guidance, based upon grounded and informed knowledge. Even with all of this knowledge, the midwife acknowledged the spiritual source of belief that also guides her work:

*Midwife's hands working sure  
Guiding you praying you  
Rotating you into the world.*

There were times that the midwife knew, through her grounded and informed knowledge, that even with all of her skills and competence, in addition, she also needed the assistance of her spiritual source and called for help: *insistent we call you*.

The midwife often called for help from her spiritual source during emergencies. For instance, during an emergency delivery even though the midwife may have *moved her hands quickly*, she also asked for spiritual assistance: *without words she called that other source to come through her, to help*. If the outcome of the complicated birth was successful and the baby born alive and crying, the midwife knew that this was in part because of assistance from a spiritual source.

*Vested in mystery  
In things unseen but known,  
Unheard, but known  
untouched, yet sensed and somehow known  
you cried.*

In another example of a common complication during birth, a very tight nuchal cord, the midwife called for spiritual succoring; *we call you, we invoke your soul in the name of almighty God & holy Trinity*. It was a combination of the midwife's resuscitative skills and the spiritual assistance that brought the baby to life.

*& then  
slowly so very slowly  
the spirit  
blossoms.*

### *Partners in Birth*

In order for the midwife to truly be with a woman during labor and childbirth a relationship between midwife and woman must be formed. The midwife had learned from her informed knowledge base of professional education, research, and through dialoguing with women and colleagues that a shared relationship was important to

women; *we will do this together*. Through her grounded knowledge of lived experience, the midwife knew that when she truly participated in the relationship, *loving, sharing, caring*, that it made the birth experience more satisfying for the mother, and herself. The midwife must have a personal belief in and understanding (self-knowledge) that each woman's labor and birth was unique and her very own special experience, *there is no routine birth*, in order to form a successful partnership with a woman during childbirth. Interpretation of the poetry revealed two action and belief oriented sub themes: (a) birth is a special experience, and (b) partnering.

*Birth is a Special Experience.* Midwives knew from grounded and informed knowledge that no two women could have the same exact birth experience and that each time a woman gave birth it was a different and unique experience. The midwife also believed that as a midwife she must treat each woman as an individual, *this woman*, and each birth *this birth*, as a special and unique experience. For each birth to be special the midwife had to be truly present and part of the relationship, working *with her*, to participate in the uniqueness of the experience. The midwife understood that for the mother and the family members present, each birth was a special experience that could never be replicated. Through the eyes of a midwife being present, one could see how a father was *steadyng the birthwork*, how a sister's eyes *glisten like jewels*, and how a god-sister began to understand *the work of birth*, for the first time. The eyes of the midwife were able to see the soon to be born baby as one:

*surrounded by those who  
waited on you  
celebrated by those who  
already loved you.*

The eyes of the midwife saw and the heart of the midwife remembered each mother that had *marveled as she reached down, drawing her daughter to her breast*. The midwife knew each birth was special as she heard a mother whisper, *I will always remember, your day, our day*. Each child born in its uniqueness was also a miracle for the mother and family: *my heart swells for the love of it, for the miracle of you*.

The midwife knew that attending a woman during childbirth was not a *routine delivery...one further procedure in a busy day* but that instead, each birth was *worth more than blood and riches & ...is wealth to us all*. It was truly an extraordinary occurrence, a miracle, that no single birth was the same:

<i>Sighs,</i>	<i>How hard you were</i>	<i>you came sliding out</i>
<i>Sounds little</i>	<i>in coming through the</i>	<i>wet into the blanket</i>
<i>By little from rising lungs</i>	<i>narrow place of birth</i>	<i>of our arms</i>
<i>And then you are home</i>	<i>you came to us finally pink</i>	<i>like a birthday balloon</i>
<i>Softly yet</i>	<i>and breathing</i>	<i>filled with dark hair.</i>

Because the midwife realized that childbirth was special and because her self-knowledge required her to be present and to participate, she did not view a woman's birth as a *normal spontaneous delivery* but instead remembered how she took:

*the time  
to pause in awe and wonder  
as that little head came slowly, ever so slowly,  
and the eyes opened and looked out with such trust  
and wisdom.*

*Partnering*. Partnering was an action and belief-oriented theme of co-participation between the midwife and the woman and her family during childbirth. The partnership consisted of a joint venture, the birth process, and was an intimate relationship that occurred during a finite frame of time. Both partners, the mother and the midwife, were shareholders in the venture. During the partnership the midwife and the woman worked



together as a team, *we will do this together*, to achieve the common goal of a safe birth that was emotionally rewarding. During the relationship the woman and the midwife often shared the same beliefs and views about childbirth.

The midwife was a share holder because of her self-knowledge and worldviews and beliefs about the following; (a) the purpose of a midwife was to be with the woman, *being with woman is truly being a midwife*; (b) birth was a blessed event, *a sacred mystery*; (c) women were powerful in birth, *pulling with the power of Labor*; (d) birth was a natural normal phenomenon, *she moans she cries tears slip past her eyes, she glows she rests*; and (e) women had a right to participate in their own birth with shared decision making *together we deliver this ONE to life*. The woman was a shareholder in the relationship because it was her pregnancy, her family, her birth and her child to be, *this is how you came to be, mother*. Though the relationship during birth was usually of a short duration, it was constituted of qualities normally experienced in long-term relationships such as intimacy, and trust:

*instantly intimate  
so that breath  
& sweat & the simultaneous  
heart felt moan  
are a common cup grasped  
& shared intensely.*

The relationship was intimate and trusted for several reasons. During childbirth, a woman was physically and emotionally vulnerable. Parts of the body that were considered private were often exposed, *she brings her knees back... forces a disc of dark hair to appear*, and even examined during childbirth. Women expressed psychological vulnerability through intense displays of emotions from pain, *it hurts so much*, fear, *I am frightened*, and joy, *my child, you are here*. Typically, these were emotions that were

usually expressed only in the presence of someone with whom one had a familiar, personal, and intimate relationship.

The midwives had a very intimate and trusted knowledge and understanding, through all three types of midwifery knowledge, about the birth process, the place of birth, and women during birth. Because of that knowledge, *I understand what women need from me*, midwives were able to partner with women and share the experience of birth using long-term relationship qualities, *issued to enter the close and private kingdom of marriage and birth*, on a short term basis, *it is a license made temporary*. Through grounded and informed knowledge the midwife was able to understand the experience of the laboring woman: *the heart beat of this very earth is pulsing deep in you and I know that you are frightened*, and then respond to it using her presence and experienced guidance, *I respond, I am present*.

Part of the sharing aspect of partnering with the woman during childbirth was that the midwife was actually present, *being at the woman's side*, and sharing in the experience, *working with her*, in whatever capacity the woman desired. Regardless of the type of emotional or physical work required by the midwife, *my job*, the midwife was there. *I am present... I will*

*Breathe with you*

*Sigh with you*

*Stay up all night with you*

*Hold your hands and cry*

*Pace the floors with you*

*Labor with you*

*Push with you*

*Celebrate with you*

*Squat with you*

*Sweat with you*

When the midwife had guided and helped the woman and her family members through the childbirth process, *your new one has arrived*, she eventually had to withdraw from the intimate part of the relationship, *at works ending she will tiptoe away gracefully & unassuming*.

The midwife had to do this so that the mother could concentrate on the new long-term intimate relationship she was building with her new born, *with the heartbond sealed at first comforting*. The midwife knew that the mother's new relationship with her newborn would become her most important priority, in order to ensure the survival and growth of her newborn, *for we are all still children who need loving touch*, and perhaps much more: *a belly means a family, a culture, a community*. Because the midwife understood *Life's plan, Love's touch*, through her self-knowledge, she was always very careful to end her partnership in an appropriate manner, *slowly deliberately, you were unswaddled, placed between your mother's breasts*. The midwife knew that in the end babies go to their mothers and that the midwife goes ...*back to her own border when the birthwork is done*.

Through the poetic voices of midwives being with woman

*This is how it was remembered.*

## CHAPTER 5

### DISCUSSION AND CONCLUSIONS

The poetry analyzed in this dissertation demonstrated the midwife's use of knowledge, spirituality, and presence to assist and be with women during labor and delivery. The purpose of this chapter was to link the types of midwifery knowledge and the themes that emerged from the data to relevant literature and to discuss the implications of the discoveries for midwifery. In addition, the strengths and limitations of the study were presented.

*Being with a woman* was a key phenomenon that permeated all themes and sub themes generated through analysis of the data. It was essential to understand the midwife's beliefs about being with a woman and to study the midwife's actions during the time of being with a woman. The midwife used multiple ways of knowing to be with a woman. How the midwife practiced the art of being with a woman depended on the presence she provided during the relationship.

#### Midwifery Knowledge

It is important for midwifery to develop its own body of knowledge specific to ways of knowing for the profession. Hagell (1989) has argued that the development of ones distinct knowledge base specific to a profession made sense since each occupational community had its own epistemology. Since Carper's (1978) original work on ways of knowing in nursing and Belenky et al.'s (1986) feminist work on women's ways of knowing, midwives, nurses and women have continued to pursue and refine a

body of knowledge about ways of knowing that were congruent with their own epistemological communities.

Church & Raynor (2000) and Davis (1995) claimed that the midwifery community openly acknowledged its epistemological roots and the art of midwifery. A discussion has begun amongst the midwifery profession to build upon Carper's (1978) and Belenky et al.'s (1986) work to define and explore ways of knowing for the profession. One theory of the midwifery model of care included a combination of knowing and understanding as a component of midwifery care (Dickson, 1996). This component was based on borrowed nursing theory (Swanson, 1993) and the Australian Standards for the Practice of Midwifery (1989). Dickson's definition of midwifery presence included professional competence in practice, as a type of knowing, and recognition of the fact that a woman was able to know what she needed (embodied power). Lehrman's (1988) theory building midwifery model of care definition of positive presence included knowledge of the women's subjective experience that was obtained from the one-on-one personal attention and constant availability of the midwife to the laboring woman (grounded knowledge).

Thompson et al.'s (1989) theoretical model of care had a philosophical underpinning from Belinky et al.'s (1986) work on women's ways of knowing. Thompson stated that midwives were constructionists interested in building knowledge in order to understand the relationships and contextual settings surrounding the care of women by midwives. Kennedy's (2000) study to learn more about the model of midwifery care found that midwives valued and believed in intuitive knowledge. Kennedy summarized intuitive knowing as a type of knowing that backed up expert

clinical knowledge and forced the midwife to re-assess a situation. In Kennedy's (1995) study, women expressed that fact that the midwife "just knew". Their knowing included intuition, experience and knowledge. These depictions of intuition were in accord with those who believed that intuition was not an irrational thought, or gut feeling, but a conscious and deliberate thinking process in a quest for meaning that simply did not follow a linear reasoning process (Easen & Wilcockson; 1996; Rew; 1986). Rew (1986) added that since women and children were the groups that were traditionally considered to think intuitively, this type of knowledge was considered inferior because it was not part of the patriarchal dominant paradigm.

#### Clinical Competence (Expert Knowledge)

All the models of care for midwifery mentioned clinical competence as a component of care (Dickson, 1996; Thompson et al, 1989; Kennedy, 1995, 2000; Lehrman, 1988). Clinical competence included being up to date in knowledge and being an expert in all components of midwifery management of care. I realized that this type of knowledge was a common thread that could be found in all of the themes. Whether the expert knowledge was a seeable skill such as CPR or simply knowing the phases of labor the midwife had to be clinically competent and professionally knowledgeable. For the purposes of this discussion this type of knowledge is acknowledged, but will not be discussed unless particularly pertinent to a theme as its technical and measurable concepts have been heavily researched (Raisler, 2000).

### *Self-Knowing*

Self-knowing, as I defined it, was the belief system of the individual midwife that steered her actions as she practiced her profession. Her beliefs were derived from both grounded and informed knowledge and her worldviews about birth, midwifery, women, and the knowledge of the differences between the medical and midwifery model of care (See Appendix C). I believe that in order for a midwife to practice being with a woman during labor, one of the components of midwifery care, she must believe that the phenomena has value and importance. In other words she must believe in the midwifery model of caring and the midwifery philosophy about caring in order to successfully practice the action of being with a woman during childbirth.

Self-knowing was very similar to Carper's (1978) personal knowing which was to know oneself. It was through the midwife's self knowing that she developed her own philosophy concerning her beliefs about being a midwife, and caring for women in childbirth. Siddiqui (1999) stated that midwives, who were in touch with themselves and about their own being, were able to provide an authentic therapeutic encounter in relationships. This concurred with Fawcett, Watson, Neuman, Walker & Fitzpatrick's (2001) theory on personal knowing which was described as knowing one's style and being authentic. To be truly authentic in a relationship required some congruency in belief systems. Howell-White (1999) described how successful provider- client relationships during pregnancy and birth were those where the participants shared the same frame of reference about care. The midwife that believed in the midwifery philosophy and model of care also believed that being with a woman during labor and birth was an important component of care.

Church & Raynor (2000), described how knowing self acknowledged the uniqueness of each individual, as found in the researcher's theme: birth is special. Knowing self allowed interactions to be reciprocal and interactive, such as those relationships in the birth themes among the partners. When one knew oneself and had strength in the knowledge of who they were there was the ability to be with someone in a situation instead of acting authoritatively over someone.

Belenky et al.'s (1986) constructive knowledge developed through the voices of women was similar to midwifery's self-knowing. Constructive knowledge for women honored the context in which a situation occurred (grounded knowledge), knowledge learned from others (informed knowledge), and the frame of reference of the knower (self knowledge). Following Belenky et al.'s (1986) discourse one could say that that when a midwife knew who she was in terms of the context of the situation, a midwife caring for and being with women during childbirth, that particular situation was effected by what the midwife considered to be true, her knowledge, and her expertise.

### *Grounded Knowing*

There was abundant evidence in the literature to support grounded knowledge as a legitimate way of knowing and guiding care in midwifery (Church & Raynor, 2000; Davis-Floyd, 1992, 1994; Jordan, 1997; Kitsinger, 1991; Klima, 2001; Oakley, 1989). Grounded knowledge was defined as the knowing that occurred from personal lived experiences with childbirth. The midwife knew how to be with a woman during childbirth because she had been present in previous births. Because of her personal experience the midwife knew how to provide experienced guidance, partner with the woman during birth, and make spiritual connections. Church & Raynor (2000) and Davis



(1995) describe how personalized thinking from lived experiences represented the art of midwifery. Grounded knowledge could be used to provide responsive midwifery care. Care was provided based upon the unique context of each birth experience, which required a unique response from the midwife. In order to respond uniquely to the experience the midwife had to be present. Grounded knowledge was similar to Carper's (1978) aesthetic knowing which emphasized the particulars of a situation instead of universal components of the situation. For example, during childbirth a woman may experience pain. The midwife could use her grounded knowledge to read the clues and use handwork to guide the woman through her unique experience of pain. Grounded knowledge required that the midwife perceive the particulars in the woman's experience by being present in the situation. From a woman's way of knowing we have learned that grounded knowledge was similar to Belenky et al.'s (1986) connected knowing which honored personal experience as being more trustworthy than authoritative knowledge.

#### *Authoritative Knowledge*

Authoritative knowledge was defined as a knowledge system, which carried more weight in a particular community than another knowledge system because it was associated with a stronger power base (Jordan, 1997). The members of the community who had authoritative knowledge often consider themselves and their knowledge to be superior (Oakley, 1989). Rafael (1996) described this authoritative type of knowledge as a power-over and stated that it represented exploitation of and control over others through patriarchal dominance. An excellent example of this was summarized from Church & Raynor's (2000) discussion concerning the use of episiotomies during birth. In the 1980's, based upon medical model authoritative knowledge, all obstetrical providers were

encouraged to cut perineal episiotomies in order to prevent stretching and future urinary incontinence. Conflicts between obstetricians and midwives occurred because midwives were hesitant to perform episiotomies based upon their grounded knowledge. It was not until the late 1980's that informed knowledge through quantitative research proved that the midwife's grounded knowledge was correct.

Through grounded knowledge, the midwife knew that it was better to power with than power over and instead shared the woman's birth experience (Rafael, 1996). In fact many advocates of midwifery argued that midwifery knowledge, through the use of intuition, gathered from lived birth experiences was authoritative knowledge (Davis-Floyd & Davis, 1996; Gaskin, 1996). This was especially true in settings such as birth centers and homebirths where the midwifery paradigm were considered legitimate and allowed to flourish (Davis-Floyd & Davis, 1996). Hays (1996) took authoritative knowledge one step further by stating that it was the midwife's use of her intuitive knowledge and midwifery knowledge that allowed authoritative knowledge and it's power to lie within the laboring woman as embodied knowledge. The midwife allowed the woman to be in power and to control her own birth experience.

### *Informed Knowledge*

Informed knowledge was defined as knowledge that was learned first from a respected source and not through personal experience. Examples of sources of informed knowledge were lectures, personal communication with colleagues, journals and books. Carper's (1978) most similar pattern of knowing was empirical or scientific knowledge. Though the midwife may have gathered knowledge from another colleague's personal experience, in general the bulk of informed knowledge referred to truths that were

considered de facto among the midwifery and obstetrical community. Church & Raymor (2000) stated that this type of knowledge was similar to Polanyi's (1966) original work, *knowing that*, a mainly cognitive process with an empirical and rational base. Informed knowledge tended to be obtained from objective and scholarly sources through linear reasoning. Belenky et al. (1986) referred to this kind of learning as procedural knowledge: that which was learned and applied with objective parameters. It must be noted that informed knowledge that was obtained from technical sources, such as a fetal monitor or from quantitative studies, that were replicable were often considered to be a more superior type of knowledge by those with authoritative knowledge and power in childbirth than grounded knowledge (Jordan 1997; Gordin & Johnson; 1999, Davis-Floyd, 1992, 1994).

#### *Conflicts between Midwifery Knowledge and Medical Knowledge*

The inherent conflict between the types of knowing for midwifery and medicine lie in each profession's different paradigms about childbirth and its operationalization (See Appendix C). Because midwifery and medicine approached childbirth from two different philosophies and paradigms there was conflict in the ways of knowing. Other conflicts arose from the use of a hospital setting that typically operated under the dominant medical paradigm and the need for midwifery collaboration with physicians who power over with their authoritative knowledge.

Medicine has traditionally been grounded in a biomedical approach that emphasized the curing and fixing of the human body (Morse, 1995). The bio-medical approach was mechanistic and supported the Cartesian view of separation of body and mind (Leder, 1984). The laboring body of women in childbirth was viewed as a machine

likely to malfunction or fail (Davis-Floyd, 1992). The biomedical approach operated within a paradigm that favored technology, a linear causal model of research and a reductionistic view of women (Kirkam, 1997; Morse, 1995). The philosophy of the medical model emphasized the risks and dangers to mother and fetus surrounding birth, the pain experienced in the birth process, and the need to use technology to master and control the event (Oakley, 1989; Jordan, 1997; Davis-Floyd, 1992, 1994; Howell-White, 1999). Gordin & Johnson (1999) described yet one more problem with technological focused childbirth care: when a machine malfunctions, care was diverted from the woman to the machine.

The midwives philosophy concerning birth was based upon caring for the individual, the belief that birth was a normal process to be guided by non technical intervention unless needed, active co participation by woman, and being with the woman as she desired (ACNM, 1989; Dower et al., 1999; Thorstensen, 2000; Thompson et al., 1989; Lehrman, 1988; Kennedy, 1995, 2000; Dickson, 1996). The midwifery concept of caring recognized each woman in a holistic context that included physiological, psychological, sociological, spiritual and economical care (Vosler, 1993). The midwifery model of care valued all forms of knowledge and specifically acknowledged affective knowledge which encompassed personal knowledge, grounded knowledge, and aesthetic knowledge. The midwifery model of care also valued the knowledge gained from both qualitative and interpretive science. In these terms knowledge might be contextual and unique to each interaction. These values and beliefs precluded the birth experience from being controlled, mastered or mass-produced.

Grounded knowledge was not honored by the dominant medical paradigm because it was hard to scrutinize in an objective scholarly way as it was based on individual situations that defied mass replication. McKay (1991) described how the use of routine procedures that treat all women alike in labor robbed them of their humanity and their unique individuality so that they could be treated as things that became objects to be *done to* instead of *doers*.

Further conflict was illustrated by the fact that 97% of births accompanied by midwives occurred in hospital settings that often subscribed to the bio- medical paradigm (Ventura et al., 1998). It was difficult to provide the close availability and presence of being with a woman during childbirth under this model of care (Williams, 2000). Hospital systems generally concentrated on saving money through cost containment measures and managed care and by cutbacks in midwifery and nursing staff with less support and education for women as the usual bottom line (Young, 2000).

By law, midwives must have a collaborative relationship with physicians in case a need arose for medical intervention or consultation (ACNM, 1992). Vosler et al. (1993) stated that the intended positive effect of collaboration, which was to assure that women has access to physician involvement if medical complications arose, became a very negative effect for midwifery and women. The negative effect was that the midwife was placed in a position of dependency upon the physician, who was not required to collaborate or have a relationship with the midwife unless desired. Therefore, the physician was ultimately in control of the woman's childbirth and decided what was safe for the woman and how the midwife would practice. When the authoritative power was

owned by the dominant paradigm it was easy for the legitimacy of another model of care to be dismissed.

There were many physicians and midwives working to ensure that collaboration was not construed as supervision or as a means of preventing the use of non –dominant paradigms of care (Baldwin, 1999). The Task Force on Midwifery stated that collaboration worked best when both professions respected each other's expertise (Dower et al., 1999) Recently a physician written editorial in *The New England Journal of Medicine* begged for physicians to stop competing with non-physician health care providers and to concentrate on working together in the interest of improved client care (Aiken, 2003).

### Experienced Guidance

Being a guide and guidance were frequent terms found in midwifery literature and in qualitative studies of women's experiences of care with a midwife (Berg et al., 1996; Bluff & Holloway, 1994; Hall & Holloway, 1997; Halldorsdottir & Karlsdottir, 1996a; Kennedy, 1995). For instance, Kennedy (1995) found that women felt guided by the midwife in a non-authoritative manner and Halldorsdottir & Karlsdottir (1996a) found that a caring midwife empowered the woman as she guided her through labor. Experienced guidance entailed knowing when to act and when to do nothing, the work of assisting as needed and providing advisement as one accompanied the woman through the journey of childbirth.

## Safety and Protection

Part of being with a woman during labor was being able to protect both the mother and the baby from untoward or dangerous events that could threaten the well being of either. It was not surprising to see this emerge as an essential theme of being with a woman. The first sentence of the ACNM (1989) philosophy for midwives acknowledged that every individual had the right to safe care. Safety was also found to be a core component of all midwifery models of care (Thompson, 1989; Lehrman, 1988; Kennedy, 1995, 2000; Dickson, 1996). In Kennedy's (1995) early work on midwifery caring, a sense of safety that encompassed the woman's trust in the nurse-midwife's knowledge and ability emerged as an essential theme. Kennedy found that the women felt safe, not because of the fetal monitor, but because of their relationship with the midwife who had knowledge and skills about childbirth. Thompson et al. (1989) also identified safety as a main concept of midwifery care and stated it should be examined from both the midwife's and the client's perspective. Part of safety was negotiating its meaning for both the woman and the midwife and to maximize safety for both people. At first, this concept might be hard to understand. However, what this meant was that midwives has always included what the mother wanted and desired as part of her birth experience in the safety equation. Wickham (2002) described how today's society unwisely believed that safety was a measurable concept. Thompson's (1989) concept of safety would argue that if it was measurable it did not include the subjective and unique experience of each birth.

Lehrman's (1988) concept of positive presence for midwifery included professional expertise and knowledge as essential components needed to ensure safety and protection. In Kennedy's (2000) most recent work, numerous traits and qualities

identified by both midwives and clients reflected the poetic interpretation of safety and protection. Kennedy's midwives had exceptional judgment and clinical skills and practiced within the midwifery circle of safety described by Burst (2000).

Safety and protection was supported in the ACNM (1989) philosophy that stressed that the profession was committed to both sound educational preparation and a method of quality assurance. In the United States, midwifery addressed the profession's need to provide client safely through three main venues. First, all educational programs must teach identified core basic clinical competencies to student midwives (ACNM, 1997). Second, graduating midwives must pass a national certifying examination. Finally, the profession dictated that all certified midwives should practice in accord with the Standards for the Practice of Midwifery (1993).

### Embodied Power

Through the midwife's supportive presence the laboring woman was encouraged to trust and believe in her own body's physical and mental strength and capability of giving birth successfully. Vosler (1993) described midwifery care as that which "assumes that women's body's are capable" and the midwives role to "empower women to take a new relationship to their bodies" (p. 298). She further described the midwife's belief that technology should not be used unless needed, supported the woman's belief that her body functioned normally during childbirth. A review of the literature found that embodied power has been called embodied knowledge by at least one midwife in her development of theory. Davis (1995) described embodied knowledge for the laboring woman as being in tune with her body, where both the woman's mind and body were unified knowers that



functioned as one. Davis (1995), Vosler et al., (1993), and Thorstensen (2000) stated that embodied power encouraged the woman to use her instincts in labor and to be responsible for her own actions.

Embodied knowledge was in direct conflict with the medical mechanical childbirth model that viewed the separation of mind and body as normal and the uterus as a machine likely to break during labor and need repair (Leder, 1984; Oakley, 1989). Oakley (1989) stated, "...pregnant women are not ambulant pelvises, but individuals with minds, emotions and complex personal and social lives (p. 216). Sterk (2002) stated "the job of the midwife is to enable the woman to trust her own knowledge on how to give birth not to deliver the baby" (p. 105).

Ratcliffe (2002) believed that through common sense it should be understood that women's bodies were valid sites of knowing. Ratcliffe (2002) argued that when medical institutions and the medical model with medical experts were considered the primary knower, birthing women were denied the voice of self-body knowledge. Ratcliffe added that the body knowing-self challenged the medical model and medical authority by "raising questions of who can speak and who can be heard" (p. 63). When a body knowing-self was encouraged to speak and have its voice heard confidence was gained in the use of their own self-knowledge in control over their birth. Lundgren & Dahlberg (1998) discovered that the midwives presence was instrumental in helping the woman to rely on and interpret her own body signals during childbirth.

McKay (1991) described how the routine use of technology, monitors and epidurals dehumanized the birth process. From her prospective the woman was no longer needed as a source of information if the machinery could provide the answers and even

less so if she could not feel her body because of an epidural. The large volume of machinery used in medicalized birth settings often left the woman feeling like an extension of the machinery and alienated from her birth experience (Gordon & Johnson, 1999; Schuiling & Sampsel, 1999). When this happened the mother's knowledge about her own body and desires were often ignored by the care-providers who were attending the machinery.

Kennedy's (2000) work on a midwifery dimension of caring found that it was important to validate the woman's work and her knowledge of her body through encouragement, which in turn, instilled even more confidence in the woman's own power during birth. The common dimensions of caring found in all the midwifery models of care included many behaviors found in the poetry, such as the use of touch and voice to provide empowerment, acknowledgement, and encouragement needed to give the woman confidence in her own powers (Thompson et al., 1989; Lehrman, 1988; Kennedy, 1995, 2000; Dickson 1996). Even early theoretical work by Thompson (1989) included the phrase "communicates that the client is the most expert person about herself" (p. 128) reflecting the importance of the women being the expert in her own body knowledge.

### Reading The Clues

This sub theme was defined, as the balance the midwife must keep between intervening and assisting during labor and birth or simply doing nothing. In order to have this skill the midwife must possess midwifery knowledge. First, she must be clinically competent and knowledgeable about labor and birth and the women's responses to both. The midwife must also believe through her self-knowledge that each woman and birth

experience was unique or there would be nothing for her to interpret. Grounded knowledge, which was similar to Carper's (1978) aesthetic knowledge, involved the direct involvement of the midwife and her presence so that she could understand and interpret the situation in its unique context and respond in an individualized manner. Rothman (1982) described how the midwifery model of care allowed midwives to read the woman's body and know how to proceed in a supportive non- interventionist manner. Because the midwife was wholly present, while being with a woman, she could use all of her senses to interpret the situation. In addition, as a woman the midwife was able to understand and comprehend her own inner voice and therefore understand that of the laboring woman (Belenky et al., 1986).

If she herself has experienced childbirth, the midwife possessed additional grounded knowledge that assisted her in interpreting another woman's behaviors and responses to childbirth (Rabuzzi, 1994). All five midwifery models of care maintained that clinical competence and being an expert in clinical judgment were both a mainstream and routine part of the midwifery model of care (Dickson, 1996; Kennedy, 1995, 2000; Lehrman, 1988; Thompson et al., 1989).

Reading the clues was most similar to Kennedy's (2000) dimension of therapeutics that was described as "how and why the midwife chooses and uses specific therapies when providing care" (p. 7). Included in this dimension was the option of doing nothing because the labor was proceeding normally and because the midwife trusted in and believed in the normalcy of birth. Also included in this dimension was the midwife being vigilant and paying attention to details in a holistic manner that took in the whole situation. However, even early work spoke about the important dimension of being with a

woman and the individual context of the situation. For instance, Lehrman's (1988) definition of positive presence included intuitive awareness, sensitivity, personal attention and a belief in the validity of the woman's experience of her individual labor. As part of positive presence, the midwife was constantly available in a one to one relationship. It was this attention to detail derived from being with the woman that allowed the midwife to interpret individual unique nuances of the individual labor and the woman's response to them and then act upon the clues.

Thompson et al.'s (1989) and Kennedy's (2000) work described how, as part of continuous assessment, the midwife must listen to the woman's responses and be able to understand and respond to both verbal and non-verbal cues. In order to read the clues the midwife must be present emotionally, physically and intuitively. The midwife must contextually be part of the situational experience to interpret how labor was progressing, how the woman was responding and what, if anything, she must do within the situation to support the woman and the process of labor.

### Handwork

This was a unique theme developed through the interpretation of the poetry that illustrated the midwife's hands as a physical manifestation of all three types of midwifery knowledge. Through self, grounded and informed knowledge the midwife knew that her hands were powerful tools in the provision of midwifery care. Kahn (1995) stated, "The language of birth should be a language of touch..." (p. 209). As part of experienced guidance the midwife could use her hands to touch a woman for comfort, reassurance or to provide pain relief. Hands could be used for assessment and evaluation of a contextual

situation such as the palpation of a contraction. *Random House Webster's Dictionary* (2002) description for *an old hand* was “a person with great skill or knowledge of something especially through long experience” (p. 595) and a *master's hand* as “skill and workmanship” indicated the importance of hands as an extension of cognitive thought and as a means of caring. The midwife used hands in a skilled and knowledgeable way to provide pain relief, comfort, confidence, and reassurance during childbirth. During emergencies midwives needed to use their hands in a skillful manner.

There was no specific mention in the midwifery models of care per se concerning the use of touch as a therapeutic part of midwifery care. This, in itself, was not bothersome as handwork could be viewed as one part of the operationalization of the theoretical construct of care. Schuiling & Sampsel (1999) described the use of touch as a therapeutic act of caring that supported the art of midwifery comfort. In addition, there were numerous references to midwifery touch as a positive and desired mode of care by childbearing women (Berg, Lundgren & Wahlberg, 1996; Bluff & Holloway, 1994; Frazer, Murphy & Worth-Butler, 1996; Hall & Holloway, 1998; Halldorsdottir & Karlsdottir, 1996a). Interestingly, Buss (1980) described midwife Jesusita's hands as one of her most consistent memories of the woman as she worked with her. She remembered her touch from embraces, to the memory of her hands stroking hers, and her personal touches of reassurance. She remembered how Jesusita used her hands for emphasis while telling stories using the oral tradition to share knowledge and information about her midwife techniques. There were no studies that evaluated the amount or types of touch used to provide comfort or pain relief by midwives, although this information was available in the anthropological and nursing professional literature.

From an anthropological perspective, midwife and childbirth advocate, Kitsinger (1997) provided a classification of types of touch in childbirth based upon its social function: (a) blessing touch, (b) comfort touch, (c) physically supportive touch, (d) diagnostic touch, (e) manipulative touch, (f) restraining touch, and (g) punitive touch. Kitsinger stated that touch could never be a neutral act but that it was either supportive or disabling during childbirth. Disabling touch, manipulative, restraining and punitive, were used by those that want to exercise power over a woman and supportive touch, by those that shared common values and beliefs about the birth experience.

Kitsinger (1997) stated that blessing touch linked the past, present, and future as it brought a spiritual power to the birth experience. In modern childbirth blessing touch was often expressed as massage or therapeutic touch, and included the modern midwife's knowledge that part of her role while being present was to be a physical bridge as spiritual powers work through her. Comfort touch, as defined by Kitsinger (1997), was the physical touch used to assist the mother in letting her own body do the work of birth. Midwives could use comfort touch to ease pain and provide emotional comfort so that the woman could use her own embodied power. Physically supportive touch was a very active touching that was seen infrequently in modern childbirth. One example would be a supportive midwife holding on to the mother and guiding and supporting her pelvis while she danced through the contractions. The last supportive type of touch described by Kitsinger was diagnostic touch. Kitsinger stated, "... the midwife uses her eyes, ears, and above all her hands to diagnose" (p. 223).

Nursing studies, however, have demonstrated that labor and delivery nurses did not routinely use comforting touch as a part of labor support or caring behaviors (Gagnon

& Waghorn, 1996; McNiven et al., 1992; Miltner, 2000). For example, McKay (1991) described three types of nursing touch for nurses; (a) being in touch, (b) hands on touch, and (c) procedural touch. Being in touch was defined as a spiritual presence equal to the phrase *touched by your presence*. When nurses were in touch, laboring women experienced more control and coped better. A hands on touch included eye contact, being close, and physical contact, such as holding and hugging. McKay stated that procedural touch, for example adjusting monitors and vaginal exams, was the least helpful to women, but it was the type of touch most commonly provided by the nurse.

I would be remiss not to examine the reason for nurse's lack of comforting touch as it could be of historical significance to the future of midwifery. Sandelwoski (2000) discussed how nurses have accepted the philosophy of physician controlled intervention and technology as more valued and important than nursing care. Gagnon et al., (1996) stated that the continued use of technology in nursing de-emphasized supportive behaviors as valid knowledge.

Sandelwoski (2000) stated nurses began to use their hands less to care for the patient and more as an extension for tools to treat the patient in the late 1940s. This initially caused a great divide in nursing between those who continued to value *handwork*, the art of nursing, and those nurses who thought the use of technology, favored by medicine, was more befitting of nursing as a science. Those in favor of technology felt it legitimized nursing as a profession instead of menial or trade labor. Sandelwoski stated that the division could be seen as hands off technologic surveillance of the patient versus hands on care, which included physical contact. Until the advent of technologic advances in childbirth, like the fetal monitors in the late 1960s and the use of

epidurals for pain in the 1980s, maternity nurses were required to have excellent observational and supportive touch skills. Technology used to provide pain relief versus hands on supportive care produced an even greater conflict in the intrapartum wards. Touch and the promotion of comfort strengthened a woman's coping responses and increased her empowerment and mastery of birth (Schuiling & Sampsel, 1999). Supportive touch in labor invoked dissonance for the dominant paradigm and those with authoritative knowledge because "comfort during labor deconstructs the biomedical meaning of pain in labor" (p. 80). It was important to note that obstetricians, not known for supportive touch, were often no longer even proficient in the use of diagnostic touch. Gaskin (1996) described how the use of ultrasound (another machine) had replaced the obstetrician's manual skills in assessment of fetal size and position. In fact, I recently noted that with a new technology, fetal pulse oximetry, instructions were included for physicians on how to find fetal position via a vaginal exam, an old skill, in order to use the technology appropriately.

There was a possible reason for the lack of data concerning the use of supportive touch by midwives. The simplest postulation would be that midwives used supportive touch frequently, but they have not documented it through scientific research. In fact there were no midwifery studies to date that consisted of examining the caring and supportive behaviors of midwives.

However, I have worried that the reason might be that midwifery was on the brink of falling into the same pattern described above regarding nursing. There may be such an extreme value placed upon the medicalized childbirth and the use of technology that it would be difficult to provide supportive hands on touch without punitive sanctions.



### Spiritual Connections

It was ironic that presence, the basis of being with woman and the central inquiry of this dissertation, was originally a liturgical concept that referred to the spiritual presence of a supreme being (Harper, 1991). Burkhardt (1998) argued that through our desire to bring love and healing into the client relationship we expressed our spirituality through our intentional presence and by having a conscious desire to be with another. This was a conscious interaction of intentionally being present (emotionally, spiritually, physically, and cognitively) in a manner that let the client feel safe and whole in a sacred space. Burkhardt added that in order to be present we must use all of our senses and our cognitive, intuitive, and spiritual knowledge to read clues and assess the situation.

Of the five midwifery models only, one mentioned the importance of spirituality, though only in terms of providing this care to the client (Dickson, 1996). The information found in Kennedy's (2000) study concerning spirituality was disconcerting. In direct contrast to the findings of this research study, Delphi rounds by midwives eliminated spirituality as a dimension of caring even though recipients of midwifery care provided a moderate consensus for spirituality. Further, midwives did not identify a generous and loving spirit as a dimension of caring even though it too had received strong consensus by the recipients of midwifery care.

Little mention of spiritual or religious information could be found in healthcare, much less midwifery literature. For example Lukoff, Provenzano & Turner's (1999) Medline search revealed 364 abstracts, only .008% of all reviewed Medline records represented spiritual issues. In midwifery texts spirituality was only briefly mentioned. There was a concern about how the midwife, as part of her presence, could provide for

the spiritual needs of her client (Walsh, 2001; Dickson, 1996; Hall, 2001). Hall (2001) stated that the glaring omission of spirituality in midwifery education, research, and practice compelled her to write her book.

### Spirituality and Midwifery Language

Kahn (1995), in a book about the language surrounding birth in our society, postulated a reason for the lack of discussion concerning spirituality. She believed that the social context of hospitalized birth under the biomedical model prevented providers and women from openly experiencing or expressing the sacredness and spirituality of birth. Kahn (1995) and Kirkham (1997) stated that since the biomedical model was a male construct it had prevented woman providers and clients from developing a language to express the creative dimensions of midwifery, such as spirituality and being present during childbirth.

In combination with Hall's (2001) remarks, this made sense as midwifery care historically was and to some extent continued to be passed down through oral communication (Fleming, 1998). For instance, when a midwife passed information to the incoming midwife through an oral report it often constituted a short tale of how the birth experience transpired from the perspective of the lived experience for mother and midwife. The report often contained the types of midwifery knowledge and knowing that were not documented in textbooks or written in the patient's chart because it was not considered legitimate knowledge by the dominant power. Bournaki & Germain (1993) added credence to this idea when they described how personal and aesthetic knowledge were communicated in the moment or the here and now of the actual experience, so they

were often communicated verbally in a retrospective manner. Perhaps this was why spirituality was found frequently in stories told by midwives and birthing women (Wellis & Root, 1987; Chester, 1998; Smith & Holmes, 1996; Bovard & Milton, 1993; Logan & Clark, 1989).

The lack of legitimization of language that expressed women- centered caring was further evidenced in mainstream nursing and midwifery texts. Walsh (2001) devoted two pages on support and presence and one on spirituality in over 500 total pages of midwifery text. Varney (1997) devoted approximately five pages in close to 900 pages on labor support and none on spirituality as she described midwifery care. Lowdermilk, Perry & Bobak (2000), a leading maternity text, did not list presence in the index and devoted approximately three pages each to support in labor and spirituality in over 1000 total pages. Suggesting a shift to open acknowledgement of midwifery knowledge, one new British textbook devoted an entire chapter to types of knowing and reflection as a way of learning from actions and experience (Frazer, 2000). Ironically, the information and concepts were formed from the types of midwifery knowing that were not valued by the dominant paradigm (aesthetic, personal grounded and self knowing) that for the main part continued to be voiced and learned in the oral tradition. Because midwifery was considered the non dominant paradigm in the hospital birth setting it's knowledge was considered less legitimate (Fleming, 1998) and in fact was often actively suppressed (Kirkham, 1997).

### Preordained Connections

In general, the only mention in current literature concerning a spiritual calling to be a midwife, found as a theme from the poetry, was in anecdotal sources and in personal narratives about being a midwife (Bovard & Milton 1993; Buss, 1980; Chester, 1998; Logan & Clark, 1991; Smith & Holmes, 1996; Wellish & Root, 1987). For the most part the personal narratives were autobiographies of retired *granny* midwives, and midwife's that did not routinely practice in the hospital setting. For instance, Bovard & Milton (1993) wrote, "Just like folks who were born to be doctors, preachers or foreign missionaries, I was born to be a midwife. I was born to help God's little one into the world" (p. 38). Buss (1980) stated that Jesusita, the midwife, felt her "understanding of midwifery was a God-given gift" (p. 7) and "... I don't know why but I always said that I'm going to be a midwife..." (p. 34). Interestingly enough, Hall (2001) stated that story telling, much like the anecdotal tales from above, might be a part of women's spirituality since it was a way of communicating a sense of self.

### Rewards and Hard Work

As part of the calling to be a midwife, the interpretation of the poetry expressed the rewards that could be found in midwifery along with the hard work. Part of the calling to be a midwife was a passion for the profession despite the hard work. Kennedy (2000) was the only midwifery model of care that included the midwife's enjoyment of her work as a dimension of the profession. Recipients of midwifery care felt a strong consensus that midwives enjoyed their work. A trait of the profession was described as a "passion for midwifery and caring for women" (Kenney, 2000, p. 19).

Again these ideas were found in midwifery stories, but not the mainstream literature. In Logan and Clark (1991), Logan talked of her love of midwifery “I’d rather see a baby be born in the world than to eat if I’m hungry” and “the hard work it involved” (p. 48). When the midwife went to a delivery “...they didn’t just go on a delivery... they was there to help with anything they could do” (p. 52). Buss (1980) stated “sometimes I don’t get much sleep for many nights....and I like it....I’m so happy all the time. It doesn’t bother me when they need me any time, day or night” (p. 35).

Smith and Holmes (1996) described the hard work of the midwife sterilizing speculums and supplies in addition to attending the births and the clinics. Chester (1998) described the common thread of burnout found in midwives from the intense emotional energy and physical work required of midwifery and the continual political struggles to practice the model of care. Chester however, also described the rewards of midwifery, some of which were found in the theme of the spiritual connection with a spiritual sense of service, but also by the shared intimacy and miracle of birth.

### Historical Connections

Midwives were proud of their ancient history and the longevity of the profession. Particularly mentioned by midwives were the references to midwifery care found in the chapters of Genesis and Exodus in the Bible (*Holy Bible*, 1962). There was abundance of literature that demonstrated how midwives felt connected to and honored their heritage. Historical connections were found in personal narratives (Bovard & Milton, 1993; Logan & Clark, 1991; Chester, 1998; Smith & Holmes, 1996; Wellish & Root, 1987) that documented early traditional midwifery and in the plethora of articles written by nurse

midwives documenting their history of being at the sides of woman during labor, their guardianship of birth as a normal process and their political struggles as a profession (Bortin, Alzugraray, Dowd & Kalman, 1994; Crowell, 1986; DeVires, 1983; Gordon, 1982; Litoff, 1982; McCool, 1989; Rousch, 1979; Tom, 1982). In addition, a further historical connection for midwifery was the idea that the midwife was the wise woman and the conduit for the numerous female goddesses and infrequent gods that presided at childbirth in almost all ancient cultures (Rabuzzi, 1994).

### Succoring Connections

The poetic interpretation revealed two beliefs and one action concerning a helpful spiritual source. First, the midwife understands that there were forces beyond her control (a supreme power) during her attendance at childbirth. Secondly, the midwife believed that at times this power worked through her in her own work. Finally, the midwife knew she could ask for spiritual help, with the most common behavior being prayer for assistance. These parts of this sub theme were not present in the midwifery models of care, nor were they discussed in contemporary peer reviewed midwifery journals. However, again there were abundant examples in personal midwifery narratives and autobiographies of all three types of succoring connections (Chester, 1998; Bovard & Milton, 1993; Smith & Holmes, 1996; Wellish & Root, 1987). Chester (1998) described faith and spirituality as one of the common threads found in 27 personal narratives of midwives. Spiritual awareness was a central theme that included prayer as a source of strength and guidance, the recognition of a spiritual source that worked through and guided the midwife, and the spiritual dimension of birth as a sacred act. Chester described

how even midwives without a personal religious involvement described how a spirit or unknown source guided their midwifery work. Buss (1980) wrote “If I am ever afraid on the way to a delivery, I pray. I pray on the way to help the lady” (p. 52). In Bovard & Milton (1993), Milton described consultations with God, and the use of prayer prior to routine births and in the request of miracles during emergencies. In Logan & Clark (1991), Logon described how “I asked God to help me to bring that baby to life if life was in it and He gave me the power to do it” (p. 88). Another source of information concerning a succoring connection was found in Ina May Gaskins (1977) legendary book *Spiritual Midwifery*. Gaskin's lone cry from the 1970s “... each and every childbirth is a spiritual experience” (p. 11) had not been supported in written word by mainstream midwifery. Gaskin described how the spiritual energy of the midwife was holy and the power of the midwife's touch was sacred energy. The spiritual midwife must possess and maintain spiritual discipline in order to bring love and compassion to childbirth.

### Partners in Birth

There was ample evidence in midwifery theory, philosophy, research and practice to support the importance of the unique relationship between midwife and woman. The two sub themes, which supported partners in birth, were birth was a special experience and partnering. The central components of these sub themes were the fact that each woman and baby was seen as an individual and each birth was a special experience. During the childbirth experience the midwife co-participated with the woman in an intimate and close relationship through her presence. After the birth the midwife encouraged a new intimate relationship (partnership) between the mother and her

newborn. Gallant, Bealieu, & Carnevale's (2002) nursing theory described partnership as a process of power sharing which empowered the client and enhanced their ability to act on their own behalf. Thompson (1989) emphasized the need to decrease power differentials between the woman and her provider in the midwifery model of care.

Both the ACNM (1989) philosophy and all five midwifery models of care (Dickson, 1996; Kennedy, 1995, 2000; Lehrman, 1988; Thompson et al., 1989) recognized as central components of midwifery care the unique individuality of each woman and her birth experience, the co-participation of the woman in a shared relationship with the midwife, and the midwife's use of her physical and emotional presence. Midwifery research that examined woman's views of their birth experiences with midwives also supported these features of being with a woman as central to midwifery care (Berg et al., 1996; Bluff & Holloway, 1994; Hall & Holloway, 1998; Halldorsdottir & Karlsdottir, 1996a, 1996b; Too, 1996; Waldenstrom et al., 1996; Walker et al., 1995; Walsh 1999).

### The Relationships

The sub themes of partners in birth, birth is a special experience and partnering, were discussed together because they were so interwoven. The intimate relationship that the midwife had when she partnered with a woman during childbirth included the belief that each birth had a specialness and was unique. Rabussi (1997) describes the partnership of being *with* woman during childbirth as critical to the midwifery model of care and a component of specialness. All five midwifery models of care (Lehrman, 1988; Thompson et al., 1989; Kennedy, 1995, 2000; Dickson, 1996) agreed that the each



woman should be treated as an individual, each birth as a unique experience and that each midwifery relationship should be based upon co-participation, trust and respect. Kennedy (1995) described one of her themes as “a caring relationship built on mutual respect, trust and alliance” (p. 415) and later (2000) described the midwife's belief that she was a guide and partner with childbearing women. Siddiqui (1999) in the latest work on the therapeutic value in the women centered midwife/client relationship indicated that compassion; presence, empowerment, commitment and the desire to be authentic were important components.

One aspect infrequently discussed in midwifery literature was the midwife's importance in starting the relationship between mother and baby off to a positive start. Rabuzzi (1993) described how the lack of early bonding could impair the capacity of the mother to develop a meaningful relationship with her baby. Rabuzzi added that just because the woman had known the fetus inside the womb did not supercede their need to develop a new relationship outside of the womb. Varney (1997), and Walsh (2001) both stressed the importance of keeping the baby with the mother, on her abdomen or wrapped in her arms for at least the first hour and encouraged early breastfeeding. Similar to the phrases interpreted in the poetry, they explained that this period of time was conducive to the new maternal –infant relationship and stressed that it was the midwives role to minimize any interference in this process. The need to focus the relationship after birth from midwife/mother to mother/infant was supported by clients in both of Kennedy's (1995, 2000) studies, but they were not identified by the midwives in the (2000) study as a therapeutic dimension that supported the normalcy of birth. Recipients of midwifery care described how the midwife unobtrusively moved to the background to provide them

their privacy in the early hours, but maintained the presence if needed to support the family dynamics and to be sure the baby and mother stayed together.

### Summary of the Discussion of Findings

The literature review for the research study indicated that models of midwifery care, midwifery philosophy and recipients of midwifery care valued the phenomena of being with a woman during childbirth. There were several parts of the phenomenon, spiritual connections and handwork, found through the interpretation of the poetry that were not supported by the midwifery theory but were supported by recipients of their care, personal stories, and narrative by midwives. I firmly believed that these areas have not received much attention because they were not considered legitimate knowledge and did not fit in well with the dominant paradigm. In an effort to escape conflict we have excluded these types of effective knowledge from our professional image. We need to develop and value the areas of spirituality and handwork. It was difficult to explore their impact on the client because they were based on the experiences and feelings of the women's experience and that was not valued in the literature.

The phenomenon of being with a woman during childbirth was contextually situated in the relationship between the midwife and the woman and her particular and unique birth experience. This was congruent with Widdershoven's (1999) care theory based upon Gadamer's analysis of interpersonal understanding in relationships. Gadamer (1989) described hermeneutical understanding as a mutual process with dialogue between both constituents in the relationship. Widdershoven (1999) stated that in the provider-client relationship "the needs of the other are not seen as a given", but "...through mutual

interaction, the needs become expressed and thereby get a concrete shape”(p 1168). This meant that the midwife gained knowledge about the experience of the woman through communication and being present. Total knowledge can never be totally construed and fixed as the situation and each act of understanding the situation is in constant flux.

### Strengths of the Study

#### *The Methodology*

One of the strengths of the study was the fact that the phenomenological, hermeneutical and Gadamerian philosophical perspective under which the study was conducted was congruent with the type of human science research van Mannen (1997) espoused. The nature of the inquiry, interpretation through writing and reflection, and the use of poetry as data were consistent with phenomenological methodology. In other, words I was meticulous about ensuring a correct fit for all components of the study, thereby increasing its credibility and dependability. Sandelowoski (1995) stated “...internal coherence within a work is often more important than consensus among scholars or critics of that work” (p. 207). In addition, the ways of knowing generated by the study were congruent with and reflective of types of knowing that were symbiotic with the nature of the inquiry: personal knowing and aesthetic knowing. Fawcett, Watson, Neuman, Walker, & Fitzpatrick (2001) claimed that personal knowing helped to describe interpersonal relationships based upon an inquiry of open thinking and reflection and esthetic knowing helped one to perceive what was significant in the particular individual. They believed good sources of data could be found in art and story, such as

the poetry used in this study, as evidence to support personal and aesthetic knowing.

### *Poetry as Data*

A second strength of the study was the fact that poetry was used as the source of data. Poetry was able to capture the deep and often-unconscious feelings about an event, emotion, or phenomenon that were expressed consciously on paper through reflection on and interpretation of the experience. Hunter (2002a) described poetry as an excellent textual medium that could illuminate the uniqueness of the provider-patient relationship, and demonstrate ways of knowing through the art of the profession. Sorell (1994) described how poetic writing functioned as art that expressed the inner self and inner speech and operated as a bridge between the past and consciousness. Sorrell added that poetry and writing released the power of the mind to recapture past life experiences. She stated previously unexplored avenues of knowing for nursing were made available through the reading and writing of poetry. Poetry enhanced the meaning of qualitative work through its textual representation. The segments of poetry that were interwoven through out the analysis was a strength of the study because it added to the aesthetic value of the study as it was read. Morse (1995) described connoisseurship in qualitative research much like that of tasting wine, where one learned to appreciate a particular work for its beauty, originality, and individual substance.

### *The Risk of Research*

A third strength of the study was the fact that I dared to do what Morse (2001) called risky research. Risky research was described as creative, innovative, and difficult, but could provide new perspectives. Morse (2001) stated it was this very type of research that was capable of changing the direction of science and how we view our world. In

order to get the most from risky research, one must be able to display the study for scrutiny and be able to understand that a study's possible limitations may be due to the fact that it explored new territory and challenged boundaries.

### *Validation of the Themes*

A fourth strength of the study was the comments provided by the content expert, an experienced midwife, who indicated that I had provided a credible interpretation of the data. The experienced midwife was given a copy of the poems and my data analysis. She was asked to answer the following question: Can you see in the written text, my interpretation and do you believe that it is a credible, plausible reality of a lived experience (Richardson, 2000). van Mannen (1997) called the use of a content expert, collaborative assistance, and believed that it strengthened the researcher work. Cohen, Kahn & Steve (2000) stated that opening the inquiry to content experts reduced bias. The content experts remarks were brief, but succinct, and supported the essential themes developed from my interpretation of the poetry concerning the phenomena of interest: being with a woman during labor. Her remarks were as follows: "well done, readable, believable, used all poems wisely, liked italics in text and that poetry was threaded throughout the chapter, plausible framework, made sense, nice balance of poems." As a midwife, she found all of the themes reflective of being with a woman in childbirth. Struck by the simplicity of some she asked "...why don't we see this in journals (spirituality)?"

## Ways to Improve the Study

### *The Depth of Data*

In retrospect, I would have done a few things differently. First, I would have gathered more data (poetry) if I had only known where to look at the time. I actually found more poetry nestled in introductions and scattered throughout many books I read that were collections of personal narratives or stories about the life of individual midwives. Ironically, I had never read this type of literature until the data analysis and search for answers lead me in that direction. After reading these stories, I discovered that many of the themes I had developed were also common threads of the personal narratives. The additional use of personal narratives or perhaps even photography of midwives being with a woman in childbirth to augment the data from the poetry might have added more dimensions and thickness to the study.

### *Committee Membership*

A second clear limitation seen in hindsight was the fact that I did not have a nurse-midwife as part of my committee. A committee member content expert, in addition to the content expert I used to read my drafts would have increased the credibility of the study. Although, the poetry could be understood by all, identification of the themes by a committee member who was a midwife might have facilitated the research process.

### *The Need for Journaling*

Finally, through experience I learned that journaling with paper and pen rather than via the computer provided a better and more comprehensive trail of my spontaneous thought processes. For this last chapter I completely returned to this process. Though laborious, I found that my best writing and interpretation was gathered first on numerous

scraps of paper and large yellow binders left in at least three places: home, car, and work. I feel that there were times when I lost important spontaneous interpretations while I was in front of the computer or without a handy note pad.

### Directions for Future Research

Raisler (2000) demonstrated that past research topics in midwifery had concentrated on much needed quantitative studies and work that validated beneficial outcomes from midwifery care, comparisons between obstetrical and midwifery outcomes, midwifery theory development, and our importance to vulnerable populations. For all practical purposes the midwifery research to date validated the midwife's competency to the dominant medical paradigm and verified that women desired the midwifery model of care (Raisler, 2000).

Future research needs to concentrate on those aspects of midwifery care that are central to the holistic women-centered paradigm. For instance, midwifery has a philosophy that states that presence with women is important, presence has also been identified in the midwifery model of care, and women say they value and desire our being with woman. Yet, midwifery research has not yet begun to examine many of the individual characteristics of midwifery presence. Research needs to concentrate on how to practice this art, and how to overcome constraints on the ability to practice being with a woman.

Burst (1990) stated that real midwifery occurred in any context or location and that real midwifery could transcend the medical paradigm. If this were true, those who are immersed in the medical model of care should still be practicing the phenomena of

being with a woman in childbirth. Future research needs to be done to discover, from both the woman's and midwives perspectives, if being with woman still occurs. If being with a woman still exists, to what extent does it exist within the hospital setting or in institutionalized birth centers. Research studies should initially concentrate on work sampling studies of midwives to identify qualities and traits of midwifery caring that are currently being exhibited. The work sampling studies should include examination of the five types of touch identified by Kitsinger (1997) to learn more about this aspect of being with the woman. At the same time qualitative studies need to be conducted, to discover what it mean's to be with a woman during childbirth and how the midwife perceives her practice of being with woman. Studies should concentrate on discovering if the phenomenon has survived in hospitalized midwifery practice and what attributes are present and through what means it has been preserved.

As an outgrowth of this study, midwives need to explore the relationship of the profession to spirituality. It was a frequently mentioned concept in personal narratives and anecdotal stories and was identified in this research (Bovard & Milton, 1993; Buss, 1980; Chester, 1998, Logan & Clark, 1991; Smith & Holmes, 1996; Wellish & Root, 1987). Though not well developed in this study it would be important to learn what are perceived to be the rewards of the profession and what constitutes the downside or hard work of midwifery. Information of this sort would be beneficial to those considering the profession and perhaps burnout could be mitigated if we knew its shape and were able to counteract it. This information may best be learned through phenomenological, and grounded theory studies that would gather data orally, as midwives tend to pass along this



type of personal and esthetic knowing from lived experience or information that is considered personal knowing (Fleming, 1998).

Midwifery needs to support and concentrate on research that defines and values knowledge specific to the midwifery profession in addition to the bio-medical method. Church and Raynor (2000) discussed professionalism in midwifery and described how reflection, which was the crux of this study, could lead us to discover different dimensions of knowledge. Qualitative midwifery studies can pursue intuition, embodied knowledge, and experiential knowledge as legitimate forms of truth.

### Implications for Midwifery Education

After conducting this study, I believe there are several areas for discussion that can contribute to midwifery education. Didactic education needs to ensure that our historical roots, past and current political struggles, and the legitimacy of effective knowing are routine topics of midwifery curriculum. These areas can be taught through reflective learning such as story telling, written narrative, and poetry. Clinically, we need to ensure that every student has the opportunity to practice in at least one service or with one midwife that believes in the midwifery model of care, has the ability to practice it without constraint, and experiences a positive collaborative model for consultation and co-management.

### Reflective Reasoning in Education

Freda (1994) stated that by the 21<sup>st</sup> century it would become popular knowledge that women and men learn differently and that both genders would move into a symbiotic

adult consciousness. Educators need to ensure that a portion of the curriculum contains role modeling and practice in the use of reflective reasoning, thinking, and exploration of effective dimensions of knowledge. Morse (1995) stated that effective knowledge must be part of the teaching strategy for students to understand how life's experiences could contribute to women's ability to be heard. Church & Raynor (2000) described a phenomenon whereby the move toward increasing theoretical knowledge in midwifery education was decreasing the opportunity to learn from experiential and practical knowledge. Carper's (1978) personal and aesthetic ways of knowing in relation to the art of midwifery need to be preserved. Concrete ways to preserve and encourage reflective thinking include story- telling, journaling after client encounters, writing poetry about clinical experiences, and required reading. In fact Jordan (1993) described how stories about particular past births told by preceptor midwives attending a current birth with a student helped with decision-making. Story- telling became a way of learning through situated experiential knowledge. Kirkham (1997) added that fictional writing could help one to reflect on areas of midwifery that were often not part of mainstream curriculum. Curriculum should include a required amount of reading and class discussion from a list that includes articles such as Carper's (1978) patterns of knowing, Church & Raynors (2000) chapter on reflection and intuition, Belenky et al.'s (1986) work on women's ways of knowing, a choice of personal narratives or anthology of midwife stories (Bovard & Milton, 1993; Buss, 1980; Chester, 1998, Logan & Clark, 1991; Smith & Holmes, 1996; Wellish & Root, 1987) and fictional writing with the midwife as a main character of the story (Bohjalian, 1997; Gelbart, 1998; Nattel, 1999; Ray, 2000; Vincent, 2002). This type of reading will ensure students are "...able to experience constructed knowledge and

understand that we are creators of knowledge” (Freda, 1994, p. 151). Bournaki & Germain (1993) added that written esthetic knowledge based on lived experiences was a way in which retrospective sharing could occur that would increase the individual readers repertoire of possibilities in future clinical situations.

A further part of the required curriculum should address the past historical struggles of midwifery and the current struggles with the dominant medical paradigm and medicalized birth with solutions and dialogue on how to minimize this problem. If we do not know where we originated, what and who we have been as a profession, it is impossible to control our future. There are numerous articles (Buus-Frank, 1999; Dower et al., 1999; Roush, 1979; Litoff, 1982; Oakley, 1989; Tom, 1982; Vosler, 1993), books or sections of books (Banks, 1999; Sterk, et al., 2002; Haire, 1972; Howell-White, 1999; Kahn, 1995; Davis-Floyd & Sargent, 1997; Goer, 1995; Rabuzzi, 1994; Sandelowski, 2000; Wertz & Wertz 1977) that could be read and discussed in terms of creating political awareness for students and strategies to work to improve the climate for midwifery practice, the legitimization of woman- centered knowing and choices for women in childbirth.

#### Future Changes for Midwifery Practice

Jordan (1997) believed that “in many situations equally legitimate parallel knowledge exists and people move easily between them, using them sequentially or in parallel fashion for particular purposes” (p 57). This is how collaborative multidisciplinary health care should work in childbirth settings.

However, (1997) Jordan also stated those with authoritative knowledge tend to make their system or paradigm appear to be a fact of nature so that it is considered reasonable enough to be unchangeable. With this type of power came the possibility of sanctions and exclusion from the authoritative group if the values were not congruent. An example of this is the fact that the medical model of care does not in general value the concept of being with a woman during childbirth even though legitimate quantitative, randomized controlled studies have shown its worth and value in terms of legitimate outcomes (Kennell et al., 1991; Klaus et al., 1986; Sosa et al., 1980).

Changes in health policy need to be made so that there is a place for birth to be a normal and natural process for low risk woman and a place for midwives to practice their profession in an atmosphere that is supportive of their philosophy and model of care. There is a need for an equal playing field for both professions and equal access for women to both paradigms of care. Klima (2001) further stated the need for power to be shared not only among providers but also with the patient as an active partner.

Klima (2001) described how it was difficult for the midwifery paradigm to function under a medical system, regulatory requirements, and oppressive relationships. Obstetricians often viewed midwives as competition to their practice and the monetary benefits of their practice. Because of their powerful lobby, the largest in the United States, they were able to have a negative influence on legislators and regulatory agents in matters that would increase midwifery independence and decrease physician control, without hurting the care provided to women in a collaborative relationship. These negative influences included the refusal of independent hospital privileges, prescriptive authority and equal third party payment (Vosler et al., 1993).

In addition, Gabay & Wolfe (1997) pointed out other common ways that physicians manipulated state law and regulations to control midwifery practice. This was through the lack of mandated insurance coverage, refusal to collaborate, and failure to or the refusal to prove adequate compensation for midwifery care. Williams (1999) also noted that the managed care model that was based on productivity had also hindered the midwifery model of care that emphasized individualized care and taking the time to know the client in a shared relationship.

As a solution to these problems health and regulatory agencies need to make sure that before any regulation, legislation, policy, or law that effects the scope of practice of midwifery is passed, it be reviewed and judged by the board or agency for that state that controls midwifery practice and by a select group of midwives. Further, all agencies that promote or dictate health care policies need to be made up of equal representation of all those parties, which might be effected, including midwifery.

Changes also need to be made in the definition of collaboration, which is required for midwifery practice, to ensure that it is not construed by the dominant medical paradigm as a way to control how and where midwives are able to practice. One way to do this is to work through state legislation to remove all supervisory language from midwifery practice regulation and replace it with a phrase that indicates the midwives ability to practice independently unless medical complications arise that require consultation and or collaboration.

Another positive option is to require interdisciplinary courses and integrated models of care for students (nurses, midwives, physicians) in health care (Roberts, 1997; Angelini, Afrait, Hodgman, Closson, Rhodes, & Holdredge, 1996). As part of these

classes, attendees should be required to dialogue about position statements on collaboration (1992) and independent nurse midwifery practice (1997) such as those produced by the American College of Nurse-Midwives. The rationale for this idea is very clear. Hankins et al. (1996) described collaborative care as “professionals working within their scopes of practice to meet patient needs without duplication of services” (p. 1014). I believe midwives have the ultimate authoritative knowledge concerning normal pregnancy and childbirth in the low risk mother and therefore should be the primary caregivers to this group of women.

### Practicing a Midwifery Model of Care

It is a sad, but true fact, that many beginning midwifery students, as a prior nurse, have never been present during a planned un-medicated birth nor experienced a labor and birth where the midwife was able to be with the woman and successfully support the woman through the use of her embodied knowledge of birth. Eatherton (2002) stated that if skills like intuition, lived experience, and common sense were not fostered the graduate midwife would remain ensconced in a medical model of care and never move past those boundaries to become a wise midwife. A minimum requirement for each educational program should be the ability to provide at least one setting for each student to have the lived experience, instead of the vicarious experience, of the midwifery a model of care that follows midwifery philosophy and care. A prime example of an excellent skill that is better taught with the inclusion of experiential learning is the use of touch during childbirth. Skills in touch can be enhanced through informal learning by observing, watching, and seeing how others use touch. Estabrooks & Morse (1992) and McKay

(1991) added that other intuitive skills such as empathy, intuiting the woman's emotional state, and conveying understanding of the emotions were skills that needed to be learned experientially and through role modeling.

If consistent role modeling for all students is to happen there will need to be changes made in health policy so that there are enough viable practices providing women-centered midwifery care. Oakley (1989) stated that if we cannot maintain the ability to practice midwifery care and teach it to future students our profession, women, and babies would suffer. If midwives can not show students midwifery care and women-centered care as a norm, future midwives will join the profession believing that these ideas make them imposters in a male dominant maternity world (Bell, 1990).

Students need to be able to experience midwifery, using the midwifery model of care, in institutions that are friendly to and respectful of midwives. Midwifery students must be able to experience the lived experience of being precepted by midwives that practice midwifery care and use woman-centered knowledge.

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APPENDIX A  
LETTERS FOR PERMISSION TO USE POEMS

April 17, 2001

TO: National League for Nursing  
Teresa M. Vagliga, Ed.D., R.N.  
Director of Research and Professional Development  
61 Broadway  
New York, NY 10006

Dear Ms. Vagliga,

I am writing to request permission to copy a poem from a National League for Nursing – published book for my dissertation in my PhD in nursing at the University of San Diego. As part of the process I will be conducting a qualitative study in which I will interpret poetry written by midwives about their experiences of being with a women during childbirth. The poem I would like to copy is as follows:

*The Essence of Midwifery* by Linda V. Walsh published in: Styles, M. S. & Moccia, P. (1993). **On nursing: A literary celebration. An anthology** (pp. 198-200). New York: National League for Nursing.

Thank you so much for this consideration.

Sincerely,

Lauren P. Hunter



03/12;/02

Dear

I am writing to ask your permission to use your poem \_\_\_\_\_ as part of my dissertation for my PhD in Nursing. As part of the process I will be conducting a qualitative study in which I will interpret childbirth and midwifery poetry to learn more about midwifery, caring, and the concept of "being with woman." Your poem or parts of it, with your permission, could be a written part of my dissertation and as such might also be part of future published manuscripts derived from the study. Please understand that if your poem is used as part of my research it will be quoted, identified and sourced appropriately via APA standards. In addition, copies of the finding will be available to those who participate in the research, as authors of the interpreted poetry.

Please sign and return this paper where indicated and return it to me in the self addressed and stamped envelope. I have included a copy for you to keep. Thank you in advance, for your consideration and support in my latest attempt to bring forth the "art and beauty" of birth and midwifery.

Blessings,

Lauren P. Hunter

I give Lauren P. Hunter permission to use my poem \_\_\_\_\_ in her dissertation and future manuscripts resulting from the dissertation.

Name \_\_\_\_\_ Date \_\_\_\_\_

FROM: Lauren P. Hunter  
5838 Soledad Rd  
La Jolla, CA 92037

March 26, 2001

Dear

I am writing to ask your permission to use your poem \_\_\_\_\_ published in *BirthWork* as part of my dissertation for my PhD in Nursing. As part of the process I will be conducting a qualitative study in which I will interpret childbirth and midwifery poetry to learn more about midwifery, caring, and the concept of "being with woman." Your poem or parts of it, with your permission, could be a written part of my dissertation and as such might also be part of future published manuscripts derived from the study. Please understand that if your poem is used as part of my research it will be quoted, identified and sourced appropriately via APA standards. In addition, copies of the finding will be available to those who participate in the research, as authors of the interpreted poetry.

Since your poem has already been published in my book *BirthWork*, a copy written book, technically I would not need your permission. However, since I am the only one who initially solicited your poems and published *BirthWork* I would not feel right if I did not receive your permission for my latest endeavor.

Please sign and return this paper where indicated and return it to me in the self addressed and stamped envelope. I have included a copy for you to keep. Thank you in advance, for your consideration and support in my latest attempt to bring forth the "art and beauty" of birth and midwifery.

Blessings,

Lauren P. Hunter

I give Lauren P. Hunter permission to use my poem \_\_\_\_\_ in her dissertation and future manuscripts resulting from the dissertation.

Name \_\_\_\_\_ Date \_\_\_\_\_

**APPENDIX B**  
**POETRY WRITTEN BY MIDWIVES**

Birth, Past, Present, Future  
Dee Wildermouth

Labor starts with nagging pain  
insistent  
localized  
low in the belly.  
waves dancing toward shore  
receding only to dance once more.  
I watch  
I sit near  
waiting for a sign  
Is this the real thing or is this a false start?  
Nagging pain, low in the belly  
starts to rise and fall  
in patterns  
faster, stronger  
The woman rocks on her knees  
She rest  
spread frog like  
loose in her body  
absorbed by her body messages.  
A primal image  
Majestic in her strength  
Calm,  
waiting,  
rocking,  
resting,  
I sit near  
I watch  
I speak in low tones to her  
murmurs of sound  
entering the removed place she escapes to

I spread a web, gossamer-like and strong as steel  
I spin a safe place for her  
while she labors  
She moans, she cries, tears slip past her eyes  
she glows, she rests  
Water the cradle holding her  
lessens labors pull  
wave after wave swelling the body taut  
crescendo, release, rest  
again and again and again  
I sit near  
I watch  
I spin a safe place for her  
Moans become cries,  
cries become breath,  
sounds breathed in, sounds breathed out  
Labor grips her in hands of steel  
Strong, intense, serious,  
She stretches her body out to escape  
Labor holds her  
Rest – come in Labors time  
She sinks into herself  
loose in her body  
traveling in a world removed, and altered state  
I sit near  
I watch  
I spin a safe place for her  
Labor strikes faster, harder  
faster, harder  
wave after wave

bring her to her knees  
She thinks she is going to die  
She has no will of her own  
She IS Labor  
I sit near  
I watch  
I spread the web, gossamer-like and strong as steel  
I spin a safe place for her  
A final cry  
“This hurts so much”  
forces a disc of dark hair to appear  
She gathers herself up  
She takes in her breath  
She brings her knees back, pulling with the power of Labor in her arms  
She bears down  
The disk of dark hair becomes the crown of life  
She bears down again  
again  
I stand over her  
offering protection  
I hold out my hands  
and touch the warm, moist head  
of the child my daughter bears  
Together we deliver this ONE to life  
To the world outside the womb  
I stand over them  
I spread the web, gossamer-like and strong as steel  
offering protection  
I speak in low tones to them,  
To myself  
Hush my child  
My child – you are here

My child – you are done  
My child – you are just beginning  
My child – I love you

(Hunter, 2000, p. 57-59)

to the doors of heaven  
Elizabeth Perdomo

Child

after your brief journey  
to the outside  
world

you rest  
so still, too small  
& pale

peace  
eased into peace

all still  
completely

never  
troubled by the cares  
& pains  
of this world

or tasting of its  
glory

moving quickly  
& slowly

as trembling hands  
work to hold  
to touch

& to disturb you  
into life

insistent  
we call you  
we invoke your soul  
in the name of almighty God  
& holy Trinity

we breath upon you  
breath

sent deep inside

moved beat upon  
beat  
towards your heart

touching  
calling, speaking  
praying, pleading  
dousing you

with Holy oils.

imperceptible  
to the outside

a start

a puff of air  
almost a glimmer

& then  
slowly so very slowly  
the spirit

blossoms.

an inner cry  
a cough, a sputter  
a struggle made  
& then comes breath

pink  
creeping little  
by little from heart  
sighs  
sounds little  
by little from rising lungs.

& then  
you are home

softly yet  
but in our midst,

creeping  
from heart to extremities  
bathes away paleness

glows as rays

of soft spring  
sunrise

Washing you into motion  
& life

& my love  
swells for the love  
of it  
for the miracle  
of you

& we all weep  
together.

(Hunter, 2000, p. 48)

Blessing of the Hands  
Nancy S. Whitson

This woman, the round circles of her body  
all her forces concentrating  
on the works of thus birth  
Our hands working with her –  
soft on her arms for comfort and confidence,  
strong against her tailbone, counter pressure to the pain  
Our hands on the emerging circle of head, adept, sensing,  
precisely balancing pressure and release  
to guide it's passage  
Our hands know this work  
We have always done this.

History is only our conscious memory  
This work we have always done all along the length of history  
We were there in every place, in every language  
Doing this work back through all days and nights and  
centuries of history  
And then further back  
Through the thousands of years before the mind's memory  
This work is as old to us as the salt in our blood  
Our souls remember  
being at the woman's side who gathers from in her self  
the power to bear this new person into the light  
Our hands remember this work  
Learned from centuries of women  
Their spirits stand by us in the birth room  
lending their skill, power and courage  
to the work of our hands.

(Hunter, 2000, p. 56)



Remembering  
Kathy VanGorder

I want to be a midwife  
Because I remember

I remember in my cells  
the wisdom and power  
of women's bodies  
knowing how to give birth.  
I remember that women  
have always birthed with women:  
wise women, gentle women,  
a cradling community of women.

I want to be a midwife  
because I remember.  
I remember my own birth.  
I remember the forceps that weren't needed  
because I was coming out  
all by myself;  
only my mother couldn't help  
and couldn't remember  
because she was drugged.

I want to be a midwife  
because I remember,  
I remember my children's births  
with gratitude that I was not drugged;  
feeling the power of my own body  
doing what women's powerful bodies have always done;  
And looked into those newly born eyes  
reflecting the wisdom of the ancients.

I want to be a midwife  
so I can help other women who remember  
and other women to remember.  
I want to share my remembering.  
I want to be a midwife  
to help change the way babies are greeted.

Because babies are born remembering.

(Hunter, 2000, p. 53)

A Midwife's Hands  
April Trout

These hands –  
    my hands –  
have measures and timed,  
    examined, supported,  
    comforted, held.

These hands –  
    my hands –  
have touched new life,  
    have guided and welcomed it  
    into the world.

These hands –  
    my hands –  
have taken part  
in daily miracles.

These hands –  
    my hands.  
A midwife's hands.

(Hunter, 2000, p. 52)

birthwork  
Elizabeth Perdomo

it is a sacred mystery  
ancient & ever  
blessed:

how one can become  
instantly intimate

so that breath  
& sweat & the simultaneous  
heart-felt moan

are a common cup grasped  
& shared intensely.

becoming entangled  
in the limbs & prayers  
& purpose of another one's  
hope & body

& her history of pain

later  
to never see that one  
again.

this place  
an office a holy trust ordained  
for healing eve's  
wound.

it is a covenant sealed  
upon the midwife's soul  
it is commandment  
& blessing.

it is a license made  
temporary:

issued to enter  
the close & private kingdom  
of marriage & birth

places walked more distantly  
in other seasons.

& with the blessing  
comes the vow

that at work's ending  
she will tiptoe away gracefully  
& unassuming

...back to her own  
border...

When the birthwork  
is done.

(Hunter, 2000, p. 46)

rosie  
Elizabeth Perdomo

blessed child  
of my older years  
you feed my soul with  
sunshine

you will the quiver  
of home  
& we pray  
to aim your arrow  
straightly...

how hard  
the hot summer  
lingered

when you flourished  
an abundant mystery within.

teetering long  
between the blessed worlds...

father  
sister & godmother  
all anxious & near you.

midwives hands working sure  
guiding you and praying you  
rotating you into the world

& all of us fervently  
pleading God.

your person  
still holds fragrance  
of a summer rose

almost too heady  
to inhale

smelling much like heaven  
& the Mother  
who touched your birth.

you came to us finally  
pink  
& breathing...

your worth more than  
riches & blood  
& life itself

is wealth to us all.

(Hunter, 2000, p. 44)

cristina elena  
Elizabeth Perdomo

I remember well  
when you came sliding  
out wet into the blanket  
of our arms

like a birthday balloon  
filled with dark hair  
& a flattened nose.

born so smoothly  
in your shiny  
bubble  
your were protected from harm  
until you had in fact  
already arrived.

cool December  
slanted morning light  
bright but gentle  
like a good friend's laughter  
yet crisp enough to quicken  
all thoughts.

surrounded by those who  
waited on you  
celebrated by those who  
already loved you

those voices you knew  
& always will know  
more of:

father love  
steadyng the birth-work  
giving us strength to stand  
& to dance

clinging to him  
our rock held fast  
in the madly swirling tides.

sister so excited  
her eyes vibrating  
glistening like jewels  
worn to greet you.

godmother  
sharing her smooth touch  
Nourishing us with  
quiet love.

god-sister  
first time to feel the awesome  
& extreme connection  
between woman & child  
& the work of birth:

the unrelenting spirit  
that charges each to enter  
the ancient caverns of wisdom  
& faith

to be changed forever.

I will always remember  
your day our  
day

with sweetness of Lucia bread  
& the circled crown  
of candlelight...

with the heartbound  
sealed at first comforting  
a new cry with sweet milky  
breasts.

you are ever Cristina  
my bright & bold  
Christmas star.

(Hunter, 2000, p. 43)

In The Palm Of Her Hand  
Karen Parker

We step away from sheltered space,  
Our teacher's eyes, her knowing face  
Amongst the challenge and change we hear,  
The voice of the dream,  
    She whispers near...  
        "keep moving, don't stop now, have no fear."

Our eyes see what's before us now.  
And sight goes farther to see just how,  
A belly means a family,  
    a culture,  
        a community.  
Although we are different as seen by some,  
In earth's great family  
    we are one.

Majestic world still holds insult.  
Our babies are hungry,  
Our ignorance at fault  
Wars they are raging,  
    a papa lies dead.  
Breastmilk replaced by her grief instead.

I can't hope to change it or make an impact.  
My work is before me,  
    each baby a truth  
that the path lies before me

I can't hope to change it or make an impact.  
My work is before me,  
    each baby a fact  
that the path lies before me  
    to try.

        To cry and then to try,  
To reach these small fingers  
    To your baby's face  
To safeguard her entrance  
And make a safe place.

Because it all starts here,  
In the fold of family.  
And it's tendrils grow outward  
To form Life's great tree  
with branches protective  
    Each child has it's own  
Worth EVERYONE'S effort  
    a safe, loving home.

For we all are still children  
Who need loving touch.  
Grown-ups or babies  
It doesn't take much.  
So we start at the entrance,  
    Life's slate is still clean  
And pray for the loving

never to wean.

Out teachers, with wisdom

Have given us start.

Life cheers us, encouraged,

for out of the heart

a midwife emerges

A part of Life's Plan

Love's touch

it is simple

in the palm of her hand.

(Hunter, 2000, p. 41)

The Calling  
Sherry Laminack

...on becoming a midwife

A calling it's called...and surely it must be,  
That we have assembled, this unlikely group,  
    to accomplish this goal we set...  
Some without even a clear understanding why,  
Except that there was this need, or this ache,  
    or this something that pushed us onward.  
Not for power, for there are many ways to wield  
    more power than we;  
Not for fame, for if we are great at our art,  
    we give the glory to those we serve.  
Not for wealth, for the riches we receive  
    are not monetary.  
As many of us know, now as we begin  
    ...it's the calling.  
The calling that causes us to leave home,  
    and hearth, and family and friends, and  
    many denounce comfortable livelihoods,  
    secure in our positions;  
To experience fear, and adversity, and feelings  
    of inadequacy...  
To be able, in the end, to fulfill the need, soothe  
    the ache, and live on purpose.  
For I, myself, would rather be at a birth  
    than to eat or sleep.  
To help a sister bring forth her child in  
    as loving and gentle way as I know how,  
And to touch the face of God in the only way  
    I know how while bound to this earth.

(Hunter, 2000, p. 32)



Labor Song  
Janice Kalman

There's a woman in the mountains laboring

There's a woman in the ocean laboring

There's a woman in the jungle laboring

And you can labor too

For the waters are flowing

And the moon she is rising

The heart beat of this very earth

is pulsing deep in you

And I know that you are frightened

Who could have thought this would be so painful

Now what you can do

Is let the rhythm carry you through

And I will breathe with you

I will sigh with you

I will hold your hands and cry with you

I will pace the floors this night with you

Until your new one has arrived

(Hunter, 2000, p. 31)

Caring  
Michuela Donahue

I speak not of the caring curriculum  
but of caring  
for each other, our clients, the planet  
ourselves; first ourselves.

We want, we say, to know  
how to delivery babies,  
how to do pelvic exams,  
how to diagnose and prescribe.

And I say, you first need to know  
how to care,  
how to listen to yourself  
and the women who come,  
who ask to be heard.

Look within  
to that space in the center.  
Ground into the earth,  
Reach up to the sky.  
Unite with the Source.  
Connect with each other.

You are women.  
You know in your core  
how to care; you are wise.  
It is this that you give.  
It is this that I share.

(Hunter, 2000, p. 18)

The Gift of The Hummingbird  
Carol Brendsel

It was the beginning of April  
when the ram's head pokes through the crown of spring  
the end of bitter winter, West Virginia, 1922.  
Cold slipped and ran down the Allegheny mountains  
settled in the gullies near the family home  
while vapors ascended from the holler  
as if releasing a long-held breath.  
The sun rose sickly and wan.

In the dark of that morning, your mother bled.  
Prostate on the board table she sagged,  
a pitiable lump underneath covers grabbed in haste  
from a bed chaste of sleep.  
The stove glowered, matched the frowns,  
the creased faces of her cousin, Lillian,  
and you father, Evan.  
The midwife's face gazed down at her, India Rebecca.  
Your mother hardly moved.  
Through her a red river surged and flowed  
with each swollen contraction.  
The memory of who she was  
spilled and saturated the bedding beneath her  
flooded the floor in bloody, uncountable drops.

Too soon it was for you to come.  
You weren't expected until the first peonies and roses opened,  
when the colors changed  
water-logged grey and dismal brown  
to riotous pinks and reds..  
They didn't expect this premature and slaughterhouse red,

Profane red, red that surrounded them in profuse shadow.  
"He should have left her alone, it was just too soon,"  
some gossips in town whispered.  
It didn't seem right for this little bird of a woman,  
who in between the four babies,  
wanted to weigh one-hundred pounds.  
But it was she who wanted another child,  
to feel the insistent demands of new life.

There was no thought for your life then,  
Only your mother's.  
You were her gift, a mere flutter from her wings,  
born in a scarlet gush.  
White and dull as an egg, clipped from her nurture,  
you were wrapped warmly, but dismissed,  
bundled into waiting arms.

Your mother, separated and as quiet as you,  
floated out on her own unseen umbilical cord.  
She trembled, moved into another body,  
this one buoyant, impeded by physical boundaries.  
Invisible, yet able to see,  
she rose and watched her loved ones below.

The midwife moved her hands quickly.  
Without words she called that other source,  
to come through her, to help.  
As if she pulled an enchanted thread,  
she summoned your mother to the one strong knot  
that would hold and secure.  
"Your baby needs you now India..."

Come and be with those that love you...  
Come, be with those you love..."  
Over and over she chanted,  
and in that moment, vested in mystery  
in things unseen, but known,  
unheard, yet sensed and somehow known,  
you cried  
and called in your own small way  
for your mother to come too.

She must have sensed your need,  
for she rushed back to her body lying there,  
reached her arms up to acknowledge you.  
Slowly, deliberately, you were unswaddled,  
placed between her breasts  
and the now, sure incantation of her heart.

This is how you came to be, mother.  
This is how it is remembered.

(Hunter, 2000, p. 13)

Sheathed  
Carol Brendsel

My poems are uneducated, ashamed they have hidden in my hands,  
good hands, experienced, midwife's hands  
where baby upon baby landed.  
Babies I gave back to their mothers,  
their rightful place,  
when baby went to breast  
my job was done.  
Sometimes, one of the reluctant ones came through.  
Ones who didn't want to make that last leap.  
Ones who perhaps took a drink, not a breath,  
who lay there limp in my hands.  
More than once I had to call them  
make their mothers call them too, tell them they're wanted,  
coax them to claim bodies designed  
especially for them.  
Some still stalled.  
They needed rubs and jump-starts, my own breath.  
I needed poems then, and prayers too,  
oh God I learned to pray.  
When it was over, I would pack up with my helpers,  
go for breakfast. I needed potatoes and bread,  
something of the earth and solid ground,  
something to remind me of just who I was really,  
untitled, unknown, a worker-in-service.  
The poems were too tired then, like me,  
they slept, came disguised as dreams.  
I ached for them, the loneliness could be so deep.  
I wanted them like the babies just born,  
slippery, wet with imagination,  
waiting to be dried and held close,  
savage and squalling with first breaths.  
The smell, the incredible smell of birth, something  
that reminds me there is always spring.  
I wanted them to come through my hands and stay,  
sublime, erudite, filled with the sense of just how much they know.

(Hunter, 2000, p. 7)

A Midwife's Prayer  
Sheila Bowen

The ring of the phone shatters  
The quiet still of the  
Early morning hour.

The darkest hour before the dawn.  
The message quickens your heart rate  
And you are on your way in minutes.

During the journey, a quick review  
Ruptured membranes? Weeks gestation?  
Primigravida, nervous, frightened.

How to calm her, reassure her  
That all is well, progressing nicely.  
We should see this baby by noon.

A prayer for wisdom  
A prayer for guidance  
A prayer for safe passage.

A plea to the Spirit of all Creation  
As new life approaches  
Always in company with the specter of Death

A crown of head appears  
One last push over a glistening perineum  
A scream mixed with agony and joy.

A brief moment of breathlessness,  
And silence, and then the welcome wail  
Which signals life.

A prayer of gratitude  
A prayer of renewal  
A prayer of life everlasting

Life, Love, and Hope restored

(Hunter, 2000, p. 6)

With Women  
Sheila Bowen

Knowing when to be silent,  
keeping vigil,  
simply listening.

Knowing when to act swiftly,  
protecting life,  
promoting life.

Saying "You can do this,"  
and believing it.  
Saying "You are important  
and make a difference."

Those in her care are vulnerable.  
She and they are in transition,  
ever at the interface  
when life begins again.

She hovers tentatively as life surges,  
sensation, pressure, pulsation,  
ebb and flow – tides  
systole - diastole  
death - resurrection.

Time and spirit inextricably woven.  
Her strength in gentleness,  
from eternity to infinity.  
The cycle repeats itself,  
and the mystery remains.

(Hunter, 2000, p. 5)

Soul Work  
Susan M. Roberts

I AM TIRED.  
I AM SO TIRED MY HEAD AND BACK IS ACHING  
I DID IMPORTANT WORK LAST NIGHT  
I DID SOUL WORK  
I AM A STUDENT,  
JUST NOW LEARNING ABOUT THE ART  
AND SCIENCE OF MIDWIFERY.  
BUT I HAVE KNOWN THE EMOTIONAL WORK  
SINCE BEFORE I WAS BORN.  
HOW DID I GET SO LUCKY?  
I DIDN'T FIND MIDWIFERY,  
IT FOUND ME.  
GOD GAVE ME A GIFT.  
AFTER ALL THE STRUGGLE AND PAIN IN MY OWN LIFE,  
I UNDERSTAND.  
I UNDERSTAND WHAT WOMEN NEED FROM ME  
AND I GLADLY GIVE IT  
I WAS UP ALL NIGHT LAST NIGHT  
WITH WOMEN WHO NEEDED ME,  
I RESPONDED TO THAT NEED  
BECAUSE I HAVE A GIFT,  
THE GIFT OF PRESENCE.  
THEY LOOK AT ME AND WITHOUT WORDS THEY SAY:  
"I AM FRIGHTENED AND I NEED YOU TO BE PRESENT,  
I NEED YOU TO HELP ME"  
AND I RESPOND  
I AM PRESENT  
TODAY A HOSPITAL ADMINISTRATOR SAID I WAS 'GOOD'



WHAT IS GOOD?  
DOES GOOD MEAN I AM EFFICIENT AND CAN  
MAKE MONEY FOR THE HOSPITAL?  
DOES IT MEAN SOME HMO THINKS I AM A  
“PRODUCTIVE MID-LEVEL PROVIDER?”  
NOT TO ME.  
TO ME, GOOD MEANS THAT I AM PRESENT  
I WILL CRY WITH YOU,  
LABOR WITH YOU,  
PUSH WITH YOU  
SQUAT WITH YOU,  
SWEAT WITH YOU,  
STAY UP ALL NIGHT WITH YOU, AND FINALLY:  
CELEBRATE WITH YOU!  
THANK YOU TO THE WOMEN WHO TEACH ME EVERY DAY,  
THE WOMEN WHO NEED ME EVERY DAY,  
BECAUSE I NEED YOU TOO  
WE WILL DO THIS TOGETHER.

(Unpublished work, Used with Permission)

THE ESSENCE OF MIDWIFERY  
Linda V. Walsh

He who uttered the words "Routine Delivery"  
Or hastily wrote "Normal Spontaneous Delivery" as  
    one further procedure in a busy day  
Couldn't have really been really with her.  
He couldn't have been  
Or he would have felt her muscles as they  
    worked  
    strained  
    pushed  
that infant into the world.  
He couldn't have been,  
Or he would have truly felt her perspiration weep from  
    her body as she reached for strength deep  
    within.  
No, he couldn't have really been with her.  
If he were, he would have appreciated her expression  
    as it changed from excitement, to concentration,  
    to fear, and to excitement and peace.  
He couldn't have held her,  
Whispering  
    "You're almost there"

“You’re doing so beautifully”

“You are so strong.”

Routine delivery.

He couldn’t have been there.

He couldn’t have taken the time

to pause in awe and wonder

as that little head came slowly, ever so slowly,

and the eyes opened and looked out with such trust

and wisdom.

Procedure—normal spontaneous delivery.

He couldn’t have been with her.

He couldn’t have marveled as she reached down,

drawing her daughter to her breast

Laughing, shouting, crying –all of the emotions of birth.

No, he couldn’t have been with her.

For she who has been with woman knows there is no

routine birth, and that delivery is not a

procedure.

Being with woman is opening up,

sharing,

loving,

caring,

Being with woman is truly being a midwife.

APPENDIX C

MIDWIFERY AND MEDICAL MODELS

## APPENDIX C

## MIDWIFERY AND MEDICAL MODELS

## "Medical Model

1. Observational knowledge is privileged
2. Doctors control the experience
3. Babies needs and safety take precedence
4. Protocol takes precedence over individual differences
5. Mothers are patients who are in pain
6. Pregnancy and birth are abnormal

## Midwifery Model

1. Experiential knowledge is privileged
2. Mothers control the experience
3. Mothers' and babies' needs are considered together
4. Individual differences take precedence over protocol
5. Mothers are subjects who are engaged in the productive work of birthing
6. Pregnancy and birth are normal"

(Sterk, 2002, p. 105)

## "...Midwifery and Obstetrics Conceptual Domains

Midwives	Obstetricians
Women	Men
Health	Disease
Normality	Abnormality
Art	Science
Social	Medical
Subjective	Objective
Experience	Knowledge
Observation	Intervention
Practice	Theory
Emotion	Reason
Intuition	Intellect
Nature	Culture
Feminine	Masculine
Community	Institution
Family	Work

Private	Public
Care	Control
Soft	Hard..."

(Oakley, 1989, p. 215).