# From Alchemy to Epistemology:

# Intuition and Private Midwifery in Australia

**Fiona Reid**

**A thesis submitted as part of the requirements for the Masters of Midwifery (Honours) degree**

**Faculty of Health, University of Technology, Sydney**

**August 2014**

# Certificate of authorship/originality

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of the requirements for a degree except as fully acknowledged in the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

_____

Fiona Reid

## *TABLE OF CONTENTS*

## List of Tables



## List of Figures

# Dedication

I dedicate this Masters Thesis to Dr Irene Leeser

1922 -

…..

I had the privilege of working with Rene at Ambajipeta Women and Children's Hospital, East Godavari, Andhra Pradesh, India, in 1984 and 1985. Rene showed me that the most influential way to impact humanity was through its women. Her grace and wisdom influenced my life forever.

…..

## Acknowledgements

My deepest gratitude to Professor Caroline Homer, my Primary Supervisor, for stimulating and encouraging intellectual curiosity and my academic development throughout the process of doing and writing research. My sincere appreciation to Dr Christine Catling, my Secondary Supervisor, for her genuine interest, encouraging comments, and invaluable feedback during the course of my study.

Thank you to the NSW Branch of the Australian College of Midwives and the NSW Health Innovations Scholarship Committee for the scholarship funding that allowed me to pursue further study.

I am indebted to UTS for their commitment to the learning environment and the provision of resources and a comfortable space in which to study.

Thank you to my research colleagues and academic mentors who have contributed to the rigour of my approach and provided unending support and collegiate interest.

Thank you, to Priya Nair, UTS, Faculty of Health Research Administrator, for her kind attention to details throughout my enrolment.

Thank you, to Patrick Tooth, Team Leader of Information Services UTS Library, who communicated with unending care and patience, both, in person and across distance for three and a half years.

Thank you, to Royal Prince Alfred Hospital, my employer, for professional encouragement and paid study leave which has made the process more manageable.

Thank you, to the midwives who allowed me to interview them and whose stories, wisdom, and knowledge are contained within this thesis. They afforded me the opportunity to analyse a richly sensuous, lived, experience that represents their courage working in the service of women and their families.

To the midwives with whom I currently practise, and to Helen Dowling, Manager of Royal Prince Alfred Hospital Birth Centre, I extend my deep respect and profound gratitude. Thank you for practising with your generosity, gentleness, commitment, knowledge and intuition every day to assist women to become mothers.

Thank you, to my dear parents, who gave me a thirst for knowledge and education and have engaged with my pursuits of both, all my life.

And finally, David, you are my bread, and salt, wise counsel and my dearest friend. Thank you.

# ABSTRACT

**Background**

Intuition entered the lexicon describing midwifery practice as early as the 14th Century and it has remained a component ever since. The Australian College of Midwives (2009) philosophical statement of midwifery identifies evidence, experience and intuition as the central responsibilities of the midwife. Many fields of science have investigated intuition however limited research has been undertaken with midwives. The aim of the study was to explore how midwives in private practice understand and use intuition in an Australian context.

**Method**

A qualitative, descriptive study was undertaken using a feminist framework. Ethical approval from UTS was sought and received prior to the study commencing. Twelve midwives in private practice were recruited using purposive and snowball sampling and advertisements were placed in two midwifery magazines. Data were collected using semi structured interviews and analysed using thematic analysis.

**Findings**

All the midwives used intuition in their practice. There were two themes, trust and knowledge, showing how the occurrence of intuition was influenced by relationships and environment. Issues related to trusting the relationship with women in their care, trusting the women and trusting themselves affected the use of intuition. Midwives also identified aspects of knowledge gained from environments that either enhanced or diminished their intuition. A lack of autonomy within institutions that are dominated by a biomedical hegemony that has become mainstream for the management of women with normal, low risk pregnancy and birth was described. Using Intuition was a fundamental part of this practice.

**Discussion**

Private midwives utilise skills that are relational, involve emotion work and use knowledge that is unique to midwifery, including intuition. This research describes private midwives' understanding of intuition and explores their use of it by using a current neuroscience interpretation called Intelligent Memory.

Midwives in private practice have often removed themselves from the governance of the institution and are more autonomous than midwives practising within hospitals. Issues about authoritative knowledge and feminist theory are discussed in light of the findings.

**Implications for practice**

The study raises implications for midwifery education and practice in light of the attributes and skills that were associated with the midwives use of intuition. Further research is required to confirm the findings of this study amongst a larger group of midwives but also to investigate midwives use of intuition within an institution. This study indicates that an understanding of intuition (Intelligent Memory) could enhance the analysis and use of intuition in midwifery training, curriculum and practice.

# Chapter 1

## INTRODUCTION

This year nearly 300,000 women in Australia will give birth and, all but a handful will rely on a midwife during their pregnancy and during the birth of their child. The Australian College of Midwives (ACM) philosophical statement of Midwifery (2009) identifies the central responsibilities of the midwife. It states:

*'Midwifery is emancipatory because it protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of the community ... it is informed by scientific evidence, by collective and individual experience* ***and by intuition.'*** (ACM 2009,p. 1)

Midwives have always used intuition as knowledge. It has developed as part of their enterprise and as a result of their experience. It has enlivened their practice and enabled them to respond to women individually and with understanding gained through the development of a relationship with the women in their care. But what is intuition and how do midwives use it?

Intuition entered the lexicon describing midwifery practice as early as the 14$^{th}$ Century (Cassidy 2006) and has remained a component of legitimate midwifery practice ever since. It involves conceptualising across, and between, different knowledge sets; formal knowledge, sensory information and physical and emotional experiences. However, it is an activity that is essentially private and unconsciously undertaken. Intuition has historically been attributed to the metaphysical realm of existence and has not been definable by reductionist analysis yet it is accepted and used by midwives throughout the world.

Developments in midwifery and medicine have been integral to each other yet modern obstetrics has considered intuition to be unscientific and invalidated its contribution to midwifery practice (Jordan 1993). The aim of this study is to explore whether Australian midwives working in private practice are using intuition in their practice and to describe how they are using it. The following research questions have been developed from this aim: Are Australian midwives in private practice using intuition? If so, what is their experience and understanding of it and how are they using it?

Effective midwifery relies on the relationship between the midwife and the woman and is one of the elements that have contributed to the current paradigms of midwifery practice

(Page 2000, 2004; Kirkham 2000; Siddiqui 1999, 2005). Little research has been done about how this relationship affects the development of midwifery skills and knowledge. Knowledge acquisition theorists (Eraut 2000, Miyake 1986) agree that knowledge creation is a fundamentally social process in nature. They appear to share with Naomi Miyake the view that social interaction provides cognitive resources for human cognitive accomplishment (Miyake 1986). According to Miyake's analysis, understanding is iterative in nature, that is, it emerges through a series of attempts to explain and understand processes and mechanisms being investigated. In a shared problem solving process, agents who have partial but different information about the problem in question appear collectively to improve their understanding through social interaction. Accordingly, new ideas and innovations largely emerge among people and groups rather than within individual people. This is true for midwives and the exchange of knowledge, skills and experience, including intuition, that has characterised the informal education of midwives since the earliest records described the passing on of the midwife's role from mother to daughter or another suitable apprentice (Cassidy 2006). In this way, a midwife developed her body of knowledge both intergenerationally and socially.

Benner's (1984) work in nursing has shown that narratives from practice can reveal new information from what has become familiar and capture the practical knowledge of nurses. There are similarities between the way nurses and midwives work. For example, narrative is used by midwives to convey and exchange information, when handing over responsibility from one colleague to another and when consulting with colleagues and medical staff. Because of these and other similarities, Benner's work could be applied to midwives.

A lot has been written about learning through reflection in practice (Jarvis 1992; Johns 2002) and how clinical experience allows the practitioner to recognise patterns that will inform the practitioner's use of knowledge based on a gut feeling or intuition (Benner 1984; Benner et al, 1996). This indicates that midwifery skills identified during narrative midwifery research can reveal hidden knowledge. Although midwives have engaged in social practices where knowledge, skills, techniques and information about women and birth have been shared in order to advance midwifery knowledge (Cassidy 2006), models of innovative educational communities indicate that an epistemological infrastructure requires a kind of social infrastructure; mere epistemology is not enough without supporting social practices, and vice versa (Miyake 1986).

Defined narrowly, epistemology is the study of knowledge and justified belief. Understood more broadly, epistemology is about issues having to do with the creation and dissemination of knowledge in particular areas of inquiry. Neuroscience has become increasingly relevant when discussing brain function and cognition. During the last 10 years, advances in neuroscience have made it possible to track the neural pathways of intuition as it occurs cognitively, in real time (Doidge 2007; Gordon 2005; Kandel 2012; Pink 2006; Ramachandran 2011) but it cannot explain what is happening. The interaction of emotional, social and unconscious brain activity involved in human relating and relationships is difficult to capture. Intuition appears to be strongly associated with relationship and the emotional connection involved in human agency (human agency is the capacity for human beings to make choices and to act in the world; Bastick 2003). There appears to be no functional difference between the male and female brain, rather, all disciplines involved with human agency have been shown to engage with intuition (Bastick 2003; Pink 2009). Midwifery is one such discipline.

This research was conducted from the point of view of midwives, grounded in empirical knowledge, their practice experiences and their epistemological position about how they as a 'knower,' know what they do (Harding 1987, p.3). The position of this research is that it is essential to cultivate reasoned 'processes of invention' that characterize scientific inquiry and to involve midwives in the same kind of extended process of problem solving through which scientists articulate new knowledge. The findings, whilst specific to an Australian context might be able to be applied to midwifery education and practice in other countries.

A qualitative descriptive methodology was used to explore and describe private midwives use of intuition. The participants in this study are all midwives working in private practice, which is a model of care where midwives work in an independent capacity and generally work with women having babies at home. Interviews will be used to provide data that will be analysed using thematic interpretative analysis. The emergence of themes will be further analysed within a feminist theoretical framework. Purposive sampling, thematic and interpretative analysis using neuroscientific theory, with the application of a theoretical framework will elicit the midwives understanding and use of intuition.

## What brought me to this study

I am a midwife working in the birth centre of a major tertiary hospital in Sydney. Like many of my colleagues, I pursued midwifery education after completing my registration as a

general nurse and I have almost 30 years of nursing and midwifery experience. Apart from occasional short-term participation in college professional development activities and conference attendance, my source of knowledge as a midwife is founded on evidence based practices, my own experiences as an ongoing learner and an essentially personal assessment of what assists and what is not effective when working with women during childbirth.

As a woman and a midwife I have found the female psyche of great importance to the work of childbirth. I have, myself, experienced how the female psyche appears to engage in intuitive thought and behaviour during the time a woman gives birth. It has been argued that this is mammalian in origin (Odent 2002), however the influence of language on both thought and behaviour (Aitchison 1976) has caused the neocortex to be involved in regulating the behaviour of the primal brain. The primal brain, mammalian behaviour and the female psyche appear to intersect during intuition. The significant contribution that female midwives make to women during childbirth is somehow central to the expression of intuition and has provided a specific route for enquiry. Developments in neuroscience have provided greater understanding of the neurophysiology of the brain and consequently the physiology of intuition has become more visible as a cognitive function that is stimulated by emotion and other factors. It has been the combination of these areas of particular interest that has brought me to investigate the role that intuition plays in the practise of midwifery.

## Organisation of the Thesis

### *Chapter one*

This chapter provides an introduction and proceeds with the background to the study and an explanation of the current terms involved in neuroscience and intuition. The history and development of midwifery in Australia is outlined and an overview of the current models of care for maternity services in Australia is described in order to provide the reader with a context for private midwifery. The current midwifery education, training and registration requirements are outlined and the chapter closes with a summary.

### *Chapter two*

Chapter two provides an examination of the current, relevant literature that relates to my research. This review includes the seven precedent studies that were found to have explored midwives' use of intuition in their practice.

### *Chapter three*

Chapter three outlines the design of the study and includes the aims, objectives, method of recruitment and the data collection techniques. A discussion of the feminist framework used to examine the political and social issues of this qualitative study is included. The concept of intuition and Intelligent Memory is further explained. How I maintained rigour during the research process is outlined and an explanation of how I situated myself within the study is explained. A discussion about reflexivity is provided.

### *Chapter four*

Chapter four examines the findings of the data and the themes that were identified in the process of analysing the data. Direct quotations from the transcripts are used to illustrate and justify the chosen themes.

### *Chapter five*

The final chapter of the thesis discusses the findings in relation to the relevant literature and identifies the implications for contemporary midwifery education and practice. It explores the political, social and cultural meaning underpinning the findings expressed by the participants and the complexities of working within a marginalised professional group. The chapter closes with the limitations of the study and a conclusion in which the main concepts and meaning of the study are reinforced. The appendices and references are presented after chapter five and complete the thesis.

This chapter now proceeds with an outline of the background to the study.

## BACKGROUND

Historically, midwifery has borrowed from medicine, nursing, sociology and psychology. This shared praxis has allowed midwifery's knowledge paradigm to be all-inclusive and holistic. As well as formal knowledge other, experiential and social contexts contribute to a midwife's training and her midwifery body of knowledge, these are; trial and error, personal experience, role modelling, reasoning, mentorship and intuition (Boxall & Flitcroft 2007; Davis-Floyd & Davis 1996; Davis-Floyd & Sargent 1997). However, midwifery has some unique professional components such as its predominately female gender, the emphasis on its role of women working with women and the use of intuition and contextual knowledge about women and the female psyche. These components of midwifery developed as part of

a midwifery paradigm, and existed prior to the dominant medical paradigm that has influenced the development of contemporary midwifery (Gaskin 1996; Oakley 1980; Mitford 1993; Davis-Floyd & Arvidson 1997). Historically, midwifery and the work and 'art' of 'being with women' has embraced emotion work, narrative meaning, sociological understanding and information relative to womens' standing in society and culture (Belenky et al 1986; Cassidy 2006; Kirkham 2000; Kitzinger 1988; Lane 2006). The next section will describe and define the concept of intuition in relation to developments in neuroscience.

## Intuition meets Neuroscience

The notion of intuition has been referred to as early as Socrates as '*a force or presence, a voice, passion or urge of certitude that impels a person to action*' (Inglis 1987, p 278; cited in Davis-Floyd and Arvidson 1997). The root of the English word derives from the Latin *intuitus* translating roughly as 'the act of achieving knowledge from direct perception or contemplation' (Davis-Floyd and Arvidson 1997, p.19). Instinct and intuition have historically been attributed to the 'gut' or 'feeling' realm of existence and intuition, or a sense of 'knowing' a thing, without explicit knowledge, has been aligned to witchcraft, alchemy, and the feminine mystique and therefore deemed unreliable in the scientific world (Ehrenreich & English 1978; Pert 1997). Nonetheless, intuition is now for the first time, visible, explicable and measureable. It may well occur in the gut but science is now able to exhibit it occurring in the brain (Doidge 2007; Ramachandran 2011; Pink 2009).

Neuroscience has contributed to the validity of intuited knowledge by identifying the metacognition (the construction of individual *meaning about one's own thought processes* developed by self-reflective practices*)* involved in its neural and synaptic pathways on functional magnetic resonance imaging (fMRI). This type of imaging (fMRI) can capture pictures of the brain in action and track blood flow during thought activities. The tracking of neuronal activity and pictures of blood flow yields a deeper understanding of the brains matrixing ability and infuses empirical knowledge with complexity, diversity and creativity (Pink 2006; Ramachandran 2011). These developments have provided a scientific legitimacy to aspects of thought and experience including intuition that have previously been considered by many to be a metaphysical occurrence. The knowledge about neurons, neuronal flow and the cellular activity of neurotransmitters in the brain is very limited (Duggan 2007). The challenge for science is to make the billions of neurons involved in

cognition, trackable, and whilst neuroscience has recently allowed us to understand some of the processes involved, it has not been possible, yet, to empirically identify what is happening in the brain during intuition (Duggan 2007; Kandel 2012). This means that the exploration of intuition necessarily continues to involve subjective reporting and analysis.

A midwife's intuition is considered unique and valuable to her practice and is part of the Australian College of Midwives description of the full scope of midwifery practice. The Australian College of Midwives describes midwifery practice as that which is *'… informed by scientific evidence, by collective and individual experience and by intuition'* (2009, p.1). This statement, which provides a mandate for midwifery practice has stimulated my research in this area. The development of intuition has been aligned to a midwife's holistic response to the labouring woman (Hunter 2007; Olafsdottir 2006). Many studies about midwifery practice mention intuition as part of the normal and accepted practice of midwives (Oakley 1980; Winter 2002; Olafsdottir 2006; Hunter 2007; Cheney 2008). However, detecting and representing intuitive knowledge has been problematic for researchers and thus has resulted in few studies. This has, in turn, had consequences for the professional acceptance of intuition when caring for women in childbirth. There is a lack of specific research about the origins of intuition and the use of intuition in midwifery practice. Midwifery researchers have linked the use of intuition to empathy between midwives and women and it has been accepted as part of female 'caring' but not accepted as the basis for scientific knowledge or evidence based problem solving and practise (Hunter 2007; Olafsdottir 2006).

Bastick, in his seminal work, links intuition to empathy and creativity (Bastick 1982, 2003). He compiled a list of 20 diverse intuitive descriptors from the global knowledge property of intuition to construct a 'Theory of Intuitive Thought' and argues that these descriptors form a reference for the fundamental organisation of intuition. Bastick's theory may be of assistance in analysing the midwives narratives in this study. Kandel's (2002, 2012) work has extended on Bastick's sociopsychological theory to provide an empirical, neuroscientific basis for the investigation of intuition. Whilst his work is about intuition, he renamed it using the term Intelligent Memory to describe the biology of neurotransmitters for neuronal activity or cognition, during the brains access of memory and stored data during intuition (Kandel 2012). Intuition, empathy and creativity are features of midwifery practice and represent a long history of women working with women during childbirth. My study is interested in the science behind a midwife's description of her cognition as she accesses

both conscious and unconscious stores of data in order to practise midwifery. These two theories are incorporated into the discussion of the study's findings in chapter five.

To help understand the positioning of midwifery within the context of maternity care in Australia it is important to outline the history and development of Australian midwifery.

## The History and Development of Midwifery in Australia

Hospital-based maternity care in Australia has dominated since the Second World War (Boxall & Flitcroft 2007). The positioning of midwifery as a distinct profession in Australia has occurred slowly and in the context of a sustained reform agenda in maternity services (Barclay 2008; Barclay et al. 2003; Fahy 2007; Hatem et al. 2009; Lane 2006, 2010; National Maternity Services Review 2008, 2009). There are currently 2,187 people registered as midwives and 39,271 registered as both nurses and midwives in Australia (Australian Health Practitioner Registration Agency AHPRA, 2011/2012 Annual Report, p. 74).

Australia uses the International Definition of the Midwife in defining the profession. The International Confederation of Midwives describes the scope of practice of midwifery and defines a midwife in the following terms:

> *'The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.*' (Revised and adopted by ICM Council June 15, 2011).

Australian midwifery has historically been a specialty qualification, gained following the completion of a General Nursing Certificate. After 2002, however, a direct entry midwifery

qualification was developed (Barclay 2008). Currently there are four ways to become a registered midwife in Australia; a Graduate Diploma, a Masters or Bachelor's Degree, a Bachelor of Midwifery and a double degree, Bachelor of Nursing/ Bachelor of Midwifery; BN/BM.

In 2008, the Australian Health Ministers Advisory Council published a report on Primary Maternity Services in which they stated that *'women must be the focus of care'* (Australian Health Ministers' Advisory Council, 2008, p.1) and identified a commitment *'...to extending and enhancing primary maternity service models as a preferred approach to providing pregnancy and birthing services to women with uncomplicated pregnancies'* (Australian Health Ministers' Advisory Council, 2008, p.1). The number of published reports at this time reflected a healthy debate about midwifery-led models of care and the strong desire by women to access the type of care they wanted. The various models of care mean that midwives work in a variety of roles and independence. Many midwives work within hospitals with a medical model of childbirth and remain attached to the medical paradigm. Others work within a midwifery paradigm using a midwifery model of care.

As well as providing free maternity care, public hospitals in Australia have increasingly provided free investigative technologies such as ultrasound and genetic testing in pregnancy and continuous monitoring, epidural and operative and surgical procedures in childbirth. Hospital-based care and an increase in technologies associated with pregnancy and childbirth has led to an increase in the medicalisation of childbirth (McLachlan et al. 2012). The medicalisation of maternity care has also resulted in care that is less woman-centred and more institutionally centred (Lane 2006). The technology that dominates maternity care is located within hospitals and so the convenience of institutionalising women in order to access that technology has been well documented (Davis-Floyd et al 2009; Davis-Floyd and Sargent 1997). This has often resulted in the emphasis of care becoming more focused on technologies and risk and less focused on the woman herself and her relationship with care providers. Studies have shown that physical and psychological birth outcomes are improved when fewer caregivers provide maternity care, with an emphasis on relationship between the clients and care providers (McLachlan et al. 2012).

Figures show that 97% of 296,925 births occurred in Australian hospitals during, 2012 (National Perinatal Epidemiological and Statistics Unit, Australian Bureau of Statistics, 2011-2012). Whilst the dominant model for maternity care is hospital-based, there are several

other models of care available to Australian women. The following section briefly describes some of these models.

## Overview of the Main Models of Maternity Care in Australia

As stated above, most midwifery care in Australia takes place in hospitals. There is a range of maternity care options available to childbearing women in Australia. It is important to describe the main models in this thesis because they provide a description of the management and care that 97% of Australian women are choosing for childbirth (Australian Institute of Health and Welfare 2012). The midwives of interest to this study are offering a model of care that is comprised of the 3% of women choosing care from privately practising midwives working outside the dominant paradigms of care. All practising midwives must be currently registered with the Australian Health Practitioners Registration Agency (AHPRA), regardless of the model and mode of practice they work in. AHPRA requires annual registration. There are currently seven major models of maternity care in Australia (Maternity Services Review 2009) although differences within these models occur nationally.

### *Public Hospital Care*

Maternity care within a public hospital is the dominant model of care provided in Australia. Women may not see the same health practitioner (midwives and medical staff) at each antenatal visit and they are likely to have another set of health practitioners attending the birth and in the postnatal period. Care in a public hospital provides services to women experiencing both normal and complicated pregnancies.

New South Wales hospitals are categorised according to their level of care. There are currently six levels within the health care system. The levels represent complexity of patient need and the number and type of specialists provided. Level 1 hospitals provide low risk antenatal care, no births and postnatal care only for women with normal outcomes. Level 2 hospitals provide maternity care for normal-risk pregnancy and births only. They have no neonatal intensive care services and are staffed by general practitioners and midwives. Level 3-5 hospitals provide low level neonatal intensive care. An escalation of care and services is provided through to Level 6, which is a tertiary hospital that provides specialist

obstetric services (supra regional) and all functions – normal, low, moderate and high-risk maternity services. Level 6 hospitals provide the highest level neonatal intensive care (Centre for Epidemiology and Research 2009).

### *Private Hospital Care with an Obstetrician*

If women have the appropriate private health insurance (or are uninsured and elect to pay) they can choose a private obstetrician to provide their antenatal care and to attend the birth. This model of care is offered in both private and public hospitals where the obstetrician holds visiting rights. This means that the obstetrician can refer the woman to the elected hospital for care and management at any time during the pregnancy and at the time of labour. Women who are receiving care by a private obstetrician usually attend the hospital for one or two antenatal visits during their pregnancy, with the bulk of their care done in the obstetrician's consultation rooms. During labour the hospital midwives manage the woman's care in consultation with the obstetrician. The obstetrician attends the birth but may also visit the woman during labour, depending on the length, complexity and management required. The obstetrician is required to visit the woman once in hospital in the postnatal period and reviews the woman in the obstetrician's rooms around six weeks after giving birth.

### *Midwives Clinics*

Midwives clinics are part of a public hospital's provision of public antenatal care. Depending on the size and level of care offered by the hospital they may offer midwife only or combined midwife/obstetrical registrar/obstetrician care during regular antenatal visits at the hospital. They generally provide care during pregnancy for women experiencing normal and low risk pregnancies however, when women deviate from 'normal' or 'low risk' during their pregnancy, the midwives are guided by consultation and referral guidelines (ACM 2013) and referral to medical care is enacted when necessary. Women then give birth in the hospital delivery ward and are attended by the midwives and doctors who are on duty at the time. The antenatal clinic midwifery staff are different to the labour ward staff and usually do not work out of their specialty areas. This model differs in rural areas where staff sometimes work across specialties and work between antenatal, delivery and postnatal

units. After the birth, midwives on the postnatal ward provide care for them. After discharge from hospital women receive ongoing care with their GP.

### *Birth Centre Care*

Birth Centres are often located in public hospitals and are a midwifery-led model of care. The midwives work across the full scope of midwifery practice and conduct antenatal visits, care during labour and birth and immediate postnatal care. Publicly funded homebirth is offered in some models by a limited number of public hospitals (Catling-Paull et al 2013). The midwives refer or work in collaboration with medical obstetric staff if complications develop. Many women elect to go home from birth centres however some women transfer to the hospital's postnatal ward where the women receive care from hospital midwives. Some women are discharged home early and have hospital midwives visiting them for between four and seven days after birth, depending on their need. Women need to be discharged within 48 hours after giving birth to access this care.

### *Team Midwifery/Midwifery Group Practice*

Team Midwifery/Midwifery Group Practice involves small groups of midwives who work together in public hospitals to provide antenatal, labour, birth and postnatal care to women who choose this model of care. Many of the larger metropolitan hospitals have team midwife programs or variations of continuity of care programs. The midwives in the group or team provide antenatal care to a number of women who select this model. Most of the antenatal visits occur at the hospital but there is provision for the midwives to do home visits when required by the women in the antenatal period. The midwives work rostered shifts and provide on-call services where women can contact them directly by phone. One of the team or group midwives attends each woman in labour and birth as required. The women choose to stay on the hospital postnatal ward or go home from the labour ward and the team or group midwives visit them daily for five to seven days.

### *General Practitioner Shared Care programs*

Most public hospitals offer women the option of having their antenatal care shared between a general practitioner (GP) and a hospital. GPs participating in shared care

programs must meet certain criteria determined by the hospital before being able to provide antenatal care. Antenatal visits are shared between the GP and the hospital with the GP responsible for the ordering and follow up of tests and pathology during the antenatal period. The woman visits the GP for most antenatal checks until she is 36 weeks pregnant. At that time the hospital takes over her care and provides antenatal, labour, birth and postnatal care. The woman resumes her GP care after discharge from the hospital.

### *Private Midwifery Care*

Private midwives work in an independent capacity and generally work with women having babies at home. Several hundred women each year in Australia choose to give birth at home (700 women had planned homebirths in Australia in 2012; National Perinatal Epidemiological and Statistics Unit, Australia; Homebirth Access Sydney 2012). These women are generally cared for by privately practising midwives. Private midwives provide antenatal, birth and postnatal support in the community to women accessing their care and as such, work with a continuity of care model.

Private midwives are self employed and registered with AHPRA. Their ethical and professional code of conduct is determined by the Australian College of Midwives. Private midwives policies and procedures are independent of institutional, medical models of care but their consultation and referral guidelines are consistent with midwifery practice determined by the Australian College of Midwives. There is no separate register or record of midwives who only work in private practice in Australia and there is no requirement at annual midwifery registration that midwives identify their mode of practice or place of work. Therefore, it is not known how many midwives are practising privately in Australia at the time of this study.

## Education and Registration

The formal education leading to registration for private midwives is the same as every registered midwife and uses the regulated competency standards for the midwife (ANMC 2006). There are currently four types of qualification available for midwives in Australia. A Graduate Diploma of Midwifery is gained by studying midwifery for 14 months as an adjunct to a Bachelor of Nursing and is largely undertaken in a hospital setting. A four-year

double degree (BN/BM) is offered in some States. A Bachelor of Midwifery is a three year degree course that does not have a prerequisite of a nursing degree and is the most recently developed midwifery qualification in Australia since 2005. A Master of Midwifery is offered as post-graduate degree and can be undertaken as coursework or research. A Certificate of Midwifery qualification existed prior to midwifery becoming a degree course and was completed in a teaching hospital over 12 months. This certificate was phased out after nursing became a tertiary degree but many currently practising midwives hold this certificate. Some private midwives have achieved endorsement by AHPRA as an Eligible Midwife. Endorsement requires a unit of tertiary study in the supply of scheduled medicines and enables midwives to prescribe and administer a range of medicines and enhances their level of autonomy. These courses are offered as six and twelve month modules and were only available by distance mode at the time of the study.

## Summary

The development of a unique body of knowledge is a characteristic of a mature profession (Friedson 1970). Midwifery is a young discipline within the academic world and there is an urgent need to identify the body of knowledge that is the foundation of the practice of midwifery and for research that reveals the complexities of practice (Siddiqui 1994). It is this study's assertion that intuition and the knowledge that arises from the relationship between a woman and her midwife is at once unique and legitimate. This knowledge, whilst appearing metaphysical, has been explained within a scientific paradigm by Bastick (2003) and within the field of neuroscience as Intelligent Memory (Kandel 2001, 2012).

It is the intention of this study to extend the understanding and documentation of intuitive midwifery knowledge in order to capture and preserve that knowledge for the benefit of midwifery practice and the education of midwives. Through this study I hope to facilitate knowledge and ensure that midwifery students are *'...able to experience constructed knowledge and understand that we are creators of knowledge'* (Freda 1994, p.151).

In the previous section I have discussed the changes in the social and cultural contexts within which midwifery knowledge has developed. Historically, only externally obtained information has been considered to be scientific, authoritative knowledge. However, due to the experiential, non-quantifiable characteristics of intuition, studies about it have relied on the qualitative nature of experience. My study depends on the participating midwives'

ability to consciously reflect on knowledge and practises that are intuitive and largely unresearched in Australia. The following literature review represents the small number of available studies that explore midwives' use of intuition. I have chosen to present these studies individually and in detail because there are so few international studies and none that I could find documenting Australian midwives use of intuition. It appears that this particular skill remains uninvestigated in an Australian context.

# Chapter 2

## LITERATURE REVIEW

This chapter presents the literature review and creates a picture about what is known about midwives use of intuition and identifies the gaps in the knowledge base. It lays the foundation for the research question I developed and the methodology used for the study. The literature review guided my research and informed my understanding of the key concepts, terminologies, ideas, and theories in the field. My reading established the state of knowledge about the research topic and enabled me to identify and evaluate relevant research methods. I have discovered that there is a dearth of research in this area. My reading of related literature has involved a process of reading generally to specifically about the phenomenon under investigation. I have chosen to present the precedent studies from the literature individually. This allows a thorough examination of the available research currently surrounding intuition and provides a sound overview of how the phenomenon has been investigated internationally. The search strategy is identified, and then the key words and phrases used in the literature search, followed by a discussion of the studies themselves.

### Search Strategy

The search strategy included a preliminary search via library databases focused mainly on qualitative research into the understanding and use of intuition by midwives. The search had to be widened when very little relevant research was found. I then used a snowball method of enquiry to search for relevant literature. This meant that the work of different authors was read as the research process evolved to expand my understanding about the origins of intuition, contemporary neuroscience and Intelligent Memory, and the role childbirth care and context plays within the history of midwifery.

A search of the literature was conducted using the data bases: Medline (OVID), CINAHL (EBSCO), MIDIRS (Maternity and Infant Care Database), Google Scholar, Cochrane Review Database, SciDirect, journals @ OVID, Elsevier, Wiley Interscience Collections Search, Informit, Promed, MIRIAD (Midwifery Research Database).

### *Key Words and Phrases*

The key words and terms used to search the literature were: independent midwifery/privately practising midwives, autonomous midwifery/midwives, autonomous role midwifery/midwives, traditional midwifery practices/skills, midwifery practices/skills, intuition, instinct, instinctual midwifery, secret midwifery/skills, innate learning/knowledge, tacit knowledge, implicit and explicit knowledge, differentiated knowledge, learning theory, neuroscientific learning, memory, pattern recognition, change theory, authoritative (midwifery) knowledge, feminism and midwifery and midwives using intuitive /instinctual skills.

The literature search was initially conducted from a midwifery standpoint but I was unable to find any studies and research related to intuition-derived practice. There was a large body of work related to decision-making based on intuition but not on skill development. Literature regarding intuition and the development of midwifery knowledge was scarce. As a result I looked outside the domain of midwifery and it was within the domain of pure mathematics that I discovered research relating to instinct led theory development. New key words (pure maths instinct, mathematical instinct) were added to the search. After reading material in mathematics I uncovered a significant paper from Iceland that strongly related to the use of intuition in midwifery practise. This paper was the only direct link to my proposed research that was within the domain of midwifery. As the search progressed and necessarily widened I found links to chess players, firemen, musicians and artists. At this point and for the purposes of this study I refocussed and narrowed the search to midwifery only. Seven relevant studies were identified and these will be discussed as the precedent studies. Table 1 provides the details of the seven studies on the following page.

**Table 1:** ***Details of the seven (7) studies identified in the literature search***

| Author | Title | Country | Year of Publication |
|---|---|---|---|
| Davis-Floyd and Davis | 'Intuition as Authoritative Knowledge in Midwifery and Homebirth' | United States | 1996 |
| Berg and Dahlberg | 'Swedish midwives care of women who are at high obstetric risk or who have obstetric complications.' | Sweden | 2001 |
| Kennedy | 'A model of exemplary midwifery practice: results of a Delphi study.' | United States | 2002 |
| Winter | 'The progress of labour: orderly chaos? How do independent midwives assess the progress of labour?' | Scotland | 2002 |
| Downe, Simpson and Trafford | 'Expert intrapartum maternity care: a meta-synthesis' | International: a metasynthesis of articles published in English | 2006 |
| Olafsdottir | 'An Icelandic Midwifery Saga Coming to Light "With woman" and connective ways of knowing' | Iceland | 2006 |
| Hunter | 'A hermeneutic phenomenological analysis of midwives' ways of knowing during childbirth' | United States | 2007 |

### *The Precedent Studies*

The development of research investigating midwives' use of intuition originates in 1996 in the United States with the work of Robbie Davis-Floyd (an anthropologist) and Elizabeth Davis (a midwife). Davis-Floyd and Davis studied intuition as an authoritative knowledge, basing their research on interviews with 22 white, middle class, American homebirth midwives. The purpose of their research was to bring attention to the midwives' use of and reliance on intuition as a guide to action and decision-making and as a salient source of authoritative knowledge during home births. The authors' intention was not to refine the concept of intuition, but simply to utilize Jordan's (1993) formulation of the notion of authoritative knowledge as a theoretical tool to help us understand the role that intuition plays for contemporary midwives. Brigitte Jordan explains the concept of authoritative knowledge:

> '*For any particular domain, several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand, or because they are associated with a stronger power base.*' (1993, p152)

Davis-Floyd and Davis found the midwife-interviewees were highly literate and competent in both technological skills and biomedical diagnosis. They also found the midwives very aware of the cultural and legal risks they run when they cannot justify their actions during a birth in logical, rational terms. For example, the deep value they placed on connection and relationship, in the context of their holistic model of birth (characterized by the treatment of the whole person, taking into account mental and social factors) and health care, led them to listen to women and follow their 'inner voice' during birth, rather than operating only according to protocols and standard parameters for 'normal birth.'

Davis-Floyd and Davis examine the nature of intuition, and consider the perceived reasons for and the consequences of the general devaluation of intuitive thinking by the wider society. An additional 20 interviews were collected after a national conference in the USA. The authors note that the midwives interviewed at the conference spontaneously provided rich narratives of their use of intuition but failed to consider the reasons for this. The midwives spoke confidently in their narratives and communicated great assurance about their use of intuition in their practice. One midwife said:

> '*I think, because we're in a culture that doesn't respect intuition, and has a very narrow definition of knowledge, we can get caught into the trap of that narrowness. Intuition is another kind of knowledge--deeply embodied. It's not up there in the stars. It is knowing, just as much as intellectual knowing. It's not fluff, which is what the culture tries to do to it*.' (Davis-Floyd and Davis 1996, p.4)

Davis-Floyd and Davis concluded that the midwives considered intuition to be integral to their practice and range of skill. Intuition was identified as a source of authoritative knowledge for all the midwives interviewed. However, there is no evidence of the authors' probing into the participants' belief systems or how they arrived at this belief about what intuition was and where it came from. The examination of the origin of intuition was not the purpose of the study; in fact the authors' make the point that the midwives believe that intuition is accessed from a spiritual or metaphysical realm. This is not to say that the midwives devalue reason and ratiocination (relating to, marked by, or skilled in methodical and logical reasoning). Davis-Floyd and Davis (1996) explain that the midwives were comfortable with their 'ratiocinative' abilities, and were keenly aware that these are culturally 'supervalued'. However, in the existing positivist, scientific model of birthing in America, the harder task, as the midwives saw it, was to identify the still, small, and culturally devalued 'inner voice'. Even so, the authors argued that midwives who act on intuition do so in opposition to the cultural consensus on what constitutes authoritative knowledge.

The study by Davis-Floyd and Davis (1996) showed that, within the US homebirth midwifery community, intuition was being used and did 'count' as authoritative knowledge. Jordan points out that '*to legitimize one kind of knowing devalues, often totally dismisses, all other ways of knowing, [so that] those who espouse alternative knowledge systems are often seen as backward, ignorant, or naive troublemakers'* (1992, p.2). Jordan's words express what the larger techno medical culture has done, in America and many other countries, to the alternative knowledge systems of midwifery.

The findings of this important study established that the midwives were using a type of care based on intuition and, that it enhanced their perceived skill and ability as midwives. Davis-Floyd and Davis (1996) found that learning to trust what was perceived as an illegitimate form of knowledge was the most challenging part of having and using intuited knowledge. Their study was the first and remains the largest study to date that investigates midwives' use of intuition.

Another important study in this area comes from Sweden. In 2001 Berg and Dahlberg studied Swedish midwives' care of women who were considered high risk or who had obstetric complications in pregnancy. The purpose of the study was to describe how expert midwives perceived their care and the components that made their care effective. They were investigating the midwives use of 'theoretical'; (educational) and 'embodied' (intuited) knowledge. The authors of this phenomenological study used audio-recorded interviews with ten midwives from four tertiary hospitals in Sweden. The midwives were purposively selected from a list of midwives who had been recognised by the Swedish Government for their level of expertise. The findings of the study were that all the midwives were using embodied or intuitive knowledge within their expert practice with high-risk women.

The findings referred to the midwives use of 'sensitive knowledge 'and their 'sensitivity for the spontaneous' as a description of their embodied knowledge. These phrases expressed the midwives capacity for intuition. Berg and Dahlberg describe this capacity as 'a developed ability to use one's senses'. One of the participating midwives says of her clients:

> '*I have to hear what she is saying. I have to hear, I have to feel, absorb what it is she wants, what she's afraid of, what she is going through...I can feel it in the air, feel it in the vibrations, I can see it in her body language, hear how she breathes, speaks*' (Berg & Dahlberg 2001, p. 263).

The authors use the transcription of the midwives dialogue for two stated purposes: firstly in order to emphasise the limits of language in description of the investigated phenomena; and secondly to emphasise the cultural use of midwifery language in describing the phenomena.

This is extremely relevant for my own study in light of Pinker's (1997) work on language and metaphor that shows that we can only describe that which we have language to attach to a description. Berg and Dahlberg (2001) also comment that midwives need to be courageous to act in accordance with intuition because of its illegitimate status within science and technocratic childbirth. The author's argue that courage is necessary especially in the context of their study of working with women at high risk; however there was no discussion about a perceived inappropriate use of intuition. Every midwife in the study described using intuition as a legitimate form of knowledge that was openly incorporated into their range of 'expert' skills.

Berg and Dahlberg's (2001) analysis of the recorded interviews used a method described by Giorgi (1997) that involves the identification of 'meaning units' and then transforming, synthesising and summarising the units in order to formulate a general structure of the phenomenon being studied. This process revealed the midwives describing their use of the dominant categories; theoretical and embodied knowledge. There was no mention of participant or external verification of the findings from the study and the reader is left unsure whether the midwives themselves engaged or agreed with the findings. Berg makes note that the other researcher (Dahlberg) was not a midwife and states that this contributed to objectivity within the study.

Another significant American study in this field initially used a quantitative and then, during the study, incorporated a qualitative approach. In 2002, Kennedy conducted a Delphi study in which 64 expert midwives and 71 recipients of midwifery care sought to achieve consensus on dimensions of exemplary care. The dimensions identified were as follows: therapeutics; how the midwife decided to use specific therapies in practice, caring; the midwife's relationship with the woman and her family, and profession; how the profession of midwifery was enhanced by exemplary practice.

As a means of corroborating these findings, 11 midwives who took part in the original study were interviewed on videotape providing narratives about their practice. All of the participants practised the full-scope of midwifery practice. Hospitals served as the birth setting for 64% of the midwives; 18% attended births at homes, and 18% did so in birth centres. Most of the participants (64%) had master's-level education. The videotapes were transcribed and analysed using constant comparative methods used in grounded theory. The findings showed that several processes of care dominated, and these results supported and extended those of the earlier study. For example, many of the midwives used the phrase *'the art of doing nothing well'* to describe a process of care centred on the midwife's presence with the labouring woman and the creation of an environment supporting pregnancy and birth as normal processes. This process included the use of education, through formal training, confidence through experience of practice and the use of intuition. The midwives referred to intuition in the context of describing their normal practice. Kennedy did not explore or explain the concept of intuition per se but the term intuition appears to be accepted as part of the midwifery vernacular and practice in the study. The author acknowledged that intuition is both complex and difficult to define and appeared to rely on other skills being in use concurrently.

Kennedy (2002) found that there was a high degree of reflective practice used by the midwives in her study. The midwives all displayed strong abilities to deal with uncertainty and rapid changes during labour. These abilities were not dependent on standardised protocols or routine techniques. The midwives expressed a need to feel 'connected 'with women in order to use their intuitive processes to deal with change and intensity whilst caring for women. In order to feel connected, the midwives expressed a need to '*know and understand*' the woman. Inherent in the findings is that intuition is reliant on a strong midwife-woman relationship. This has implications for models of maternity care and the acceptable or possible use of intuition within those models. What is apparent from Kennedy's study is that the educated, experienced, confident and reflective midwives involved in exemplary midwifery practice who participated in the study used intuition as a normal component of their work in caring for women.

The next illustrative study relevant to my work is Winter's (2002) research about how midwives assess the progress of labour. Winter's research was a qualitative study using a grounded theory approach. A sample of six, purposely selected, independent midwives were interviewed using semi-structured interviews. Three main categories emerged from the data: the first was 'knowing', comprising of different types of knowledge (including intuition) that the midwives used to make decisions. The second, 'physical knowledge', included observation of various signs displayed by the woman during labour and the third was 'knowledge of the woman in labour'. Winter found that the midwives were able to develop a complex and diverse range of knowledge and skills working outside the institution and without the constraints of medical and institutional timeframes and protocols. Their knowledge assisted them in assessing the progress of labour. The midwives described their relationship with women as the foundation of their knowledge, especially, their intuitive knowledge.

Winter's (2002) study found that the concepts of sense, subconscious, intuition and instinct (as well as energy/power/spirituality) are interrelated. She found that these factors were connected by an unseen 'knowing' that Winter states cannot be verified in any way. The midwives found it difficult to define what this sense of 'knowing' was; nevertheless they referred to it frequently. From the midwives' accounts it appears that sensing, subconscious and intuitive skills were more difficult to express and they are most easily represented by an example of a situation that has taken place or a metaphor. This is demonstrated by the author asking the midwives what instinctual meant to them. One midwife said:

> '*I don't know, I don't know. It's what we discussed, we don't know whether it's because you have experience somewhere along the line that given a particular circumstance that you recall that from your subconscious or whether it's, I don't know, I can't separate the two*.' (Winter 2002, p. 91)

This quote suggests that the subconscious may be a storage place for experience that cannot be erased but is able to be accessed when caring for women.

Winter's (2002) study portrayed how midwives closely related the subconscious and instinct to each other. There was also a suggestion that their philosophy of normality in birth was in some way connected to that subconscious place which would affect the intuition or output from the subconscious. Despite the fact that the respondents identified intuition as very important, on occasion they appeared to struggle to separate it from other terms such as instinct and subconscious. Winter did not define or discriminate between the terms. Winter (2002) also found that midwives' needed to be trustworthy with the knowledge they received through intuition. They felt that if the knowledge gained from intuition was reliable and true enough, they should not compromise it for the acceptance of other professionals. Their comments indicate that they believed that intuition has substance rather than being something more ethereal. The midwives felt that relying on and using intuition required integrity and demanded an appropriate response at a professional level.

Winter (2002) failed to describe intuition as distinct from instinct, sensing and subconscious. This appeared to be a problem of language usage and an inability to clearly develop categories from themes within the analysis and may have been largely due to the small number of midwives participating in the study. Although Winter only interviewed six midwives, they accounted for 18% of independent midwives practising in Scotland at the time of the study. The amount of dialogue and narrative did not appear to allow for a saturation of terms used by the midwives and may have affected Winter's ability to develop clear themes and categories. Winter's emphasis appeared to be on the construction of a model for understanding 'knowing' however a lack of distinction between meshed terms used by the midwives in their interviews creates confusion around their use of intuition specifically. Although Winter's sample is small, in light of the paucity of research studies found in a search of the literature, her study contributes significantly to the body of literature about midwives use of intuition.

The next study was undertaken in 2006 by three UK researchers, Downe, Simpson and Trafford. These authors conducted a systematic review and meta-synthesis of published articles in which they explored the accounts of intrapartum midwifery skills, practices, beliefs and philosophies given by practitioners considered expert, exemplary, excellent or experienced. Their search was conducted by hand and electronically and yielded 15,000 papers from 12 databases and 50 relevant health and social science journals published in English between 1970 and June 2006. They used pre-defined search terms, inclusion, and exclusion as well as quality criteria. Seven papers met the criteria for the review. Ten themes were identified and, following discussion; three intersecting concepts were identified: wisdom, skilled practice (of which intuition was part of) and enacted vocation. The authors describe the concept of enacted vocation as part of expert practice where practitioners appear to enact the '*value and to express qualities such as trust, belief and courage, to be more willing to act on intuition and to prioritise connected relationships over displays of technical brilliance'* (Downe, Simpson & Trafford 2006, p. 136). These skills had not been previously identified together.

The three concepts provided the authors with material for the development of a theory of expert intrapartum, non-physician maternity care. This appears to be the first definition of 'intrapartum expert' or 'midwife expert' in the literature. The study also provided insight into aspects of clinical expertise. The researchers concluded that maternity models of care that limit the capacity of expert midwives to use their knowledge and skills within the dominant medical paradigm may not deliver optimal midwifery care. They also stated that '*If further empirical studies verify that the identified domains maximise effective intrapartum maternity care, education and maternity care systems will need to be designed to accommodate them.'* (Downe, Simpson &Trafford 2006, p. 1)

Prior to the work by Downe, Simpson and Trafford (2006) there had been no agreed characteristics for non-medical experts in maternity care settings. The authors concluded that the predominant technocratic system of intrapartum care does not permit non-physician intrapartum caregivers, including midwives, to exercise their expertise as described within the three identified concepts (wisdom, skilled practice and enacted vocation). This finding has implications for the protection of normal birth and the wellbeing and safety of mothers and infants. Significantly, the researchers identified the use of intuition as an integral characteristic of non-medical, expert, intrapartum care.

To further extend these concepts, inner knowing, a concept close to intuition, was studied by Olof Asta Olafsdottir in 2006. This was a qualitative narrative study undertaken within a midwifery empirical paradigm to explore the 'inner knowing' of Icelandic midwives. An ethnographic narrative approach was used. The study had two parts after initial interviews revealed an unanticipated yet dominant theme. Olafsdottir initially interviewed six midwives, five of whom had more than 40 years practice and a sixth, more than 25 years of midwifery practice. Olafsdottir was less concerned with formal education and more interested in knowledge and ways of knowing that the midwives themselves had developed. The midwives were purposively selected from a cohort grounded in their empirical knowledge and their epistemological position of '*holders of known midwifery knowledge'.* The aims of the initial interviews were to explore midwifery storytelling in order to identify cultural and everyday working life attributes of Icelandic midwives; and, to develop midwifery knowledge that would inform childbirth care, practice and education.

The ways of knowing identified within the initial interviews were intuitive and spiritual; Olafsdottir wanted to understand how that knowledge developed and what it consisted of. This led to a third aim: to explore midwives' birth stories that focus on the relationship between the woman and the midwife as fundamental to the midwives' inner knowing. This subsequently led to a second round of interviews with a further 11 midwives. The midwives in the second group had between 2 and 36 years of practice. Olafsdottir bases her discussion about 'inner knowing' on Belenky et al.'s (1986) seminal work about 'Women's Ways of Knowing'. Their research is fundamental to subsequent studies about women's legitimate, authoritative knowledge. Belenky et al. (1986) described ways of knowing, that women reported, were based on their individual life experiences. In the process, the authors' identified particular ways of knowing that women have cultivated and valued; ways of knowing, they argue, that have been denigrated and neglected by the dominant intellectual ethos of our time. When developing their theory of knowledge, Belenky et al. were concerned to understand '*how women know what they know'*. They believed what women considered to be truth and reality affects the way in which they see the world, including, perceptions of self and views of teaching and learning. Their work shows how women's self concepts and ways of knowing are intertwined. Moreover, they show how women struggle to claim the power of their own minds.

Olafsdottir describes the Icelandic context of the study as significant because of the cultural acceptance of spiritual connection and belief surrounding intuition. In her study, Olafsdottir

found that the Icelandic midwives interviewed considered intuition to be spiritual not cognitive in origin. This is interesting to note as my own study seeks to establish a cognitive basis for the origin of intuition. As a result I need to reflect on my own potential cultural, western bias toward cognition and positivist neuroscientific approach to intuition rather than Olafsdottir's holistic, mind-body approach that she has established exists in Icelandic culture. Olafsdottir's study found that the midwives believed inner knowing exists prior to formal education and then connects with different knowledge systems in order to liberate intuition.

In summary, Olafsdottir found that Icelandic midwives consider intuition as existing from birth, spiritually based and integral to expert midwifery practice. Fundamental to their use of intuition was their belief that connection with the woman and her family was linked to their inner knowing.

The final study reviewed in this section was by Hunter (2007). She analysed midwives' `ways of knowing' in her qualitative hermeneutic phenomenological study of ten poems that captured and expressed their intuitive knowledge about childbirth. Hunter used textual analysis to explore the capacity and quality of intuitive interaction between midwives and the women they work with. Hunter's study was inspired by Van Manen's (1990) human science approach. According to Van Manen, human science scholars are not only researchers but also authors for whom the practice of writing constitutes a special dimension of their work. The more 'qualitative' the method (in a phenomenological sense), the more demanding is the writing. Indeed, Van Manen (1990) argues that it is in the act of reading writing that phenomenological insights are gained. In the study, Hunter (2007) explores Tandon's (1989) three ways of knowing – thinking, feeling and acting. Tandon (1989) argues that these three aspects underpin the intuitive process that is comprised of intellectual strategy, behavioural expression and the 'Outside World'. These three aspects represent the idea that Hunter (2007) found expressed in the midwives' poetry; the idea that experiential knowing arises through participation with others.

Whilst Hunter's work has limited applications, her research establishes a new way of understanding the midwife's lived experience of midwifery and midwifery knowledge. Hunter's research emphasises the perceived legitimacy of intuition by the midwives themselves as part of holistic care of the woman in childbirth. Every poem contained expressions of intuition and moments of 'knowing' derived from personal or 'self' knowledge as well as from the midwives' personal lived experience working with women

during childbirth. Hunter's work aligns her with researchers who believe that a reductionist view of midwifery constricts the profession and the opportunity to develop midwifery knowledge.

## Summary

There exists a large body of literature that explores a variety of themes, questions and studies around what happens at birth. A small number of these have explored midwives using intuition during their care of women in labour and I chose to focus on these in this literature review. All of these studies have been conducted in a European context. None have been identified as relating to the use of intuition in an Australian context. This could be because intuition is 'knowledge' that is held and used outside of regular institutional practice and shared informally through the relating of birth stories. The study I undertook sought to understand whether private midwives were using intuition in their practice. This study was conducted in the context of Australian midwifery, as private midwives practise it. It relies on the narrated details of the working lives as told by the midwives themselves, and is unique because it explores private midwives perspectives on a topic that has not previously been investigated in Australia. Chapter three outlines the design of the study and includes the aims, method and methodology. The chapter begins by identifying the research questions.

# Chapter 3

# METHODS

## Introduction

The purpose of this study was to explore the use and understanding of intuition by private midwives in Australia. The research questions were: Are Australian private midwives using intuition in their practice? And, if so, what is their experience and understanding of it and how are they using it?

This chapter presents the methodology and methods used in the study. Initially, the chapter discusses the elements of qualitative research and justifies the use of this approach for the study. A definition of intuition is followed by a working definition of intuitive knowledge that is provided to support the study's emphasis. The study's feminist framework is identified and the ethical considerations surrounding the study are discussed. The participants and the setting are described and the inclusion and exclusion criteria for the study outlined.

The chapter then documents the steps involved in designing and conducting the study whilst drawing supporting evidence from the literature for the decisions and choices that I have made. The components of data collection; interviews, field notes and data storage are discussed followed by an explanation of the analysis process used. A description of thematic analysis including a table (Table 1) showing one of the study's initial data coding frameworks is presented. The chapter proceeds with a description of how I sought verification of the analysis. Included in this section is a discussion about how the issues of rigour, validity and trustworthiness were addressed. The chapter concludes with a section describing how I situated myself within the study and includes a discussion about reflexivity. The next section describes the suitability of a qualitative method for the study.

### *Qualitative Research*

The exploratory nature of this study began with my observation from clinical practice that midwives include the language of 'intuition' when describing their daily work. In order to capture descriptions of their use of intuition and move the study from anecdotal observation toward verification I chose a qualitative research method. This method was

most congruent with the question as an examination of the use and understanding of intuition was necessary. In view of the exploratory nature of the study, I included 'description' (Sandelowski 2000) in the method because I was reliant on the midwives' descriptions of the phenomena under investigation; hence this is a qualitative descriptive study about Australian private midwives use of intuition.

In my exploration of the best approach to take I examined different authors' definitions and descriptions of qualitative research. One important author in this area, Silverman (2010), regards quantitative and qualitative approaches to research as "*complementary parts of the systematic, empirical search for knowledge"* (p. 8). Whilst there are multiple ways to study 'being' and 'knowledge' in human sciences, postmodernism challenges the idea that there is one correct way to study truth and reality in order to develop knowledge (Bloomberg & Volpe 2008; Steen & Roberts 2011; Munhall 2012). Qualitative research is suitable for exploring, discovering or describing a phenomenon or social setting from the participants' perspective (Bloomberg & Volpe 2008; Silverman 2010; Munhall 2012). Qualitative research does not practice reductionism and separate human experience into measureable parts for separate investigation (Munhall 2012) and this suited my approach and questions.

The main challenge therefore was, how to study this evasive and mostly non-conscious phenomenon using a scientific method (Bastick 1982; Petitmengin-Peugeot 1999). As Davis-Floyd and Arvidson (1997) have demonstrated, this may necessitate an interdisciplinary approach that merges insights from diverse perspectives. Unfortunately, such attempts are rare although a variety of disciplines, including neuroscience, psychology, and phenomenology, have attempted to study intuition (Kandel 2012; Doidge 2012; Duggan 2007; Pinker 1997). I chose to incorporate neuroscience into the study to facilitate a broader context for the understanding of the cognition and complexity of intuition as a brain function.

The study sought to understand the phenomenon by exploring, discovering and describing midwives' unique and subjective understanding of intuition through their narration about their own experience. Qualitative methods are characterised by 'inductive reasoning, contingency, subjectivity, discovery, description and process orienting' (Munhall 2012, p. 83). The qualitative researcher usually begins with an experience or phenomenon central to understanding and study. Interaction and narrative are used to explore the complexity and the reality as well as the nuance of that experience or phenomenon. In the qualitative method the researcher is 'unknowing' and the participant becomes the expert – the one

who holds the knowledge. This is a very different orientation to quantitative research and emphasises the uncertainty, unpredictability and serendipitous nature of an exploratory qualitative method.

Whilst studying research methods I became convinced that a qualitative approach would enable me to make a deep analysis of the data collected in the study (Silverman 2010). I was not interested in making systematic, quantitative comparisons in order to account for the variance in the phenomenon of intuition and as my literature search revealed, the published literature on my topic was predominantly qualitative research. A synthesis of literature about management and intuition revealed self reported questionnaires represent the most commonly used method in quantitative studies; however they appear to capture only some facets of the phenomenon (Bloomberg & Volpe 2008 Steen & Roberts 2011; Munhall 2012).

It was apparent that in order to answer the research question, the phenomenon under study was unable to be defined by a numerical value or score (Minichello et al 2004; Burns & Grove 2005; Schneider et al 2007; Bloomberg & Volpe 2008; Silverman 2010, 2011; Steen & Roberts 2011; Munhall 2012). It was possible that some aspects of the midwives' use and understanding of intuition would be measureable but intuition comprises both cognitive and affective, subjective elements that result in direct knowing without any use of conscious reasoning. Therefore it appeared critical to use individual narrator's ideas and concepts to adequately explore intuition in this context. The next section describes the descriptive design and methodology of the study.

### *A Qualitative Descriptive Study*

Descriptive studies primarily determine 'what is', for example in this study; what are midwives conscious of doing when using intuition? Many studies tend to discover cause and effect relationships and test theories of practice; however phenomena need to be described before attempting to explain them (Silverman 2010). This study provided an opportunity to stimulate vibrant accounts of intuition as described by the participating midwives, an aspect of midwifery practice not previously researched in Australia.

A qualitative descriptive study (Sandelowski 2000) would answer the research question because of its behavioural origins as a methodology for understanding the unique, dynamic, holistic nature of complex human behaviour. An investigation of relevant literature (Berry

1986; Sandelowski 2000, 2004; Minichello 2004; Bloomberg & Volpe 2008; Steen & Roberts 2011: Burns & Grove 2005; Grbich 1999; Denzin and Lincoln 1994) confirmed that a qualitative descriptive approach was appropriate. I decided that a descriptive approach would best assist in trying to discover meaning rather than causality in private midwifery practices in order to form theories for building midwifery knowledge (Thompson 2004; Ehrenreich & English 2005; Homer 2005; Nicholls 2006). The next section defines intuition and provides background to the study's methodological emphasis.

### *Observing and Describing Intuition*

When heuristics and rationality intersect with emotion, imagination and memories, thoughts become crystallized into occasional insights or intuition (Eisenhardt & Zbaracki 1992, 1997; Shapiro & Spence 1997). This effect is often described as a 'flash of insight', an epiphany or 'gut feeling' (Eisenhardt & Zbaracki 1992). These descriptions have been catalysed by developments in neuroscience and psychology and are consistent with those who stress the importance of a multidimensional perspective where the brain networks its regions simultaneously, creating order from a 'storm' of information (Kandel 2002; Pinker 1997). Prior to these developments it was thought that the brain regions functioned more independently of each other (Agor 1986, 1989; Bastick 1982; Forgas 1994; Lieberman 2000; Kandel 2012). There are a number of linguistic and conceptual differences surrounding intuition. Despite this, three commonalities have been identified. These are that intuitive events originate beyond consciousness; that information is processed holistically; and that intuitive perceptions are frequently accompanied by emotion (Bastick 1982; Pinker 1997; Shapiro & Spence 1997).

Intuition as a construct has been immune to scientific inquiry for centuries (Kandel 2012). It has been too elusive to define and too difficult to measure with instruments prior to developments in neurophysiology and neuroscience. It was considered a metaphysical occurrence, something akin to magic and alchemy and consequently relegated to the realm of philosophy (Doidge 2012; Kandel 2012; Petitmengin-Peugeot 1999). Recent developments in brain science have resulted in terms and language that describe unconscious, intuitive cognitive processes that are communicated through feelings and images that were previously difficult to observe, describe and map (Petitmengin-Peugeot 1999; Doidge 2012; Kandel 2012).

The theme guiding the decision to investigate intuition has been articulated by Morgan; *'To steer clear of the delusion that it is possible to know in an absolute sense of 'being right' and devote our energies to the more constructive process of dealing with the implications of our different ways of knowing*' (1983, p. 18). This study has also allowed me to explore epistemology, the branch of philosophy that deals with knowledge and how we come to know about the world as we experience it. The experiential component of knowledge acquisition is well understood in midwifery (Davis-Floyd & Arvidson 1997; Davis-Floyd & Sargent 1997; Gaskin 1996; Oakley 1980) and is relevant to understanding how a midwife accumulates knowledge and skills. This will be discussed with relevance to how that in turn contributes to intuition. The next section uses current literature to show how intuition is a form of knowledge.

### *Intuition as Knowledge*

Munhall (2012) describes intuitive knowledge as an accepted epistemology. She states that intuitive knowledge is; '*knowledge within a person, in the form of insight that becomes present in consciousness; an idea or thought produced by a long process of unconscious work. This process of discovery is nurtured through experience of the world'* (Munhall 2012, p.73). Munhall further states that intuition is the form of knowledge least attended to, but holding the most potential for nursing research and enquiry. Other highly significant scientists have also written about intuition. For example, when speaking about his discoveries in science, Einstein said; '*The only really valuable thing is intuition'* (Bargmann 1954). Many scientists have acknowledged the forces of spontaneity, accidental discovery and 'luck' in the pursuit of scientific discovery (Pink 2009). It would therefore seem reasonable that all sources of knowledge and patterns of knowing that assists scientific methods should include intuition.

The lack of agreement about what constitutes intuition, accentuated by a lack of vocabulary and terminology, has resulted in inconsistent or even contradictory definitions. This makes it difficult to compare findings across studies. Even more disconcerting is the vagueness of many available definitions. This subsequently poses difficulties for research replication. Some measures have not withstood the test of factor analysis (Agor 1986, 1989). This may be the most reassuring indication that to explore the midwives' understanding of intuition with a qualitative method is worthwhile. The next section describes the feminist framework that has informed the study and will contribute to the analysis.

### *A Feminist Framework*

Situated in an interpretive paradigm and grounded in a feminist epistemology the feminist framework has enabled me to make explicit some of the effects of gendered socialisation roles. These roles are historically important for understanding the development of the profession of midwifery and feminism has provided a framework with which to explore issues of power, knowledge and language in the provision of services for women. Midwifery is a predominantly female gendered profession and therefore it can be argued that because of its historical oppression by a male medical model of 'obstetrical management', the study calls for a feminist framework. Intuition is described within the Australian College of Midwives (ACM) (2009) philosophical statement of midwifery practice and yet intuitive practices have not been formally taught and may not have been previously documented. It is my hypothesis that, if these practices exist, they form a body of knowledge that can contribute to, and complement, existing evidence-based practice for midwifery education and its unique professional knowledge base.

Trust and feminism are tightly bound within the literature (Harding 1987; Smith 1987). Feminists have argued that trust is a fundamental part of the interdependence of persons both in the accumulation of knowledge and in social life (Govier 1992; Harding 1987; Smith 1987). They have proposed that trust is a requirement of caring, ethics and partnership. Feminist standpoint theorists make three principal claims: firstly that knowledge is socially situated; secondly, that marginalised groups are socially situated in ways that make it more likely for them to be aware of the effects of inequitable power relations and ask questions about those relationships than it is for the non-marginalized; and finally, research, particularly focused on power relations, should begin with the lives of the marginalised (Smith 1987; Harding 1987).

Within this argument is an inherent issue about dynamical law or the 'natural' process of birth and the marginalization of midwifery, which is a profession historically, focused on the 'natural' process of birth. The conflict lies in the definition of 'natural' in an increasingly medicalised and 'un-natural' birth process in which 'un-natural' is becoming normal. The natural process of birth is unreliable because it is not concrete nor is it lineal or determined to proceed in a repeated manner for every woman. Birth is at once personal and unpredictable. It is one of the last domains of humanness that science and medical science has sought to understand and control in order to limit risk and reduce harm (Ehrenreich & English 2005). This has contributed to a disregard for intuition as midwifery knowledge that

is unsupported by 'scientific' investigation. It has also resulted in the subordination of midwifery in Australia and the marginalisation of private midwives who operate outside the constraints of medical institutions in order practise using all their skill and knowledge without censure and control (Lane 2006). Whilst 'men' of science have historically used a combination of science, guesswork, the authority of power and the hierarchy of knowledge to control the birth process and women's bodies, midwives have historically sought to align themselves with the women in their care (Cassidy 2006; Floyd & Sargent 1997). The obvious gender dichotomy and power hierarchy inherent in the history of childbirth and the dualism that gendered care professionals (obstetricians and midwives) bring to birth is both political and personal. Birth is political because of the development of a triangulation of interests; the obstetrician, the woman and the midwife and has resulted in midwives who maintain a private practice to provide independent midwifery and woman centred care (Bourgeault, Benoit & Davis-Floyd 2004; Ehrenreich & English 2005).

The critical questions that a feminist framework provides this study with are the marginalising effects of the profession of midwifery as it became subordinate to the profession of medicine in the realm of childbirth (Ehrenreich & English 2005). The effect of the subordination of the midwifery resulted in midwives choosing to practise privately in their professional role (Bourgeault, Benoit & Davis-Floyd 2004; Ehrenreich & English 2005). Due to the small number of midwives in this role, they have become marginalised by the dominant model of childbirth care and carers within hospitals. This has resulted in the marginalisation of their knowledge and knowledge formation, however, as argued by Smith (1987) and Harding (1987) this marginalisation has made it more possible for them to be aware of things and ask questions regarding their practices. As a consequence, this research has begun with the lives and knowledge of private midwives.

Feminist standpoint theories emerged in the 1970s, in the first instance from Marxist feminist and feminist critical theoretical approaches within a range of social scientific disciplines (O'Reilly 2004). Feminist scholars working within a number of disciplines—such as, Dorothy Smith (1987), Sandra Harding (1987), and Patricia Hill Collins (1986) —have advocated taking women's lived experiences, particularly experiences of (caring) work, as the beginning of scientific enquiry. Central to all these standpoint theories are feminist analyses and critiques of relations between material experience, power, and epistemology, and of the effects of power relations on the production of knowledge. This study argues

that intuition is a form of knowledge being used by private, female midwives as a component of their practice.

Meyers (2010) argues that central to feminism is the desire for all women to maintain agency. Feminist philosophy supports women's right to independence and control over their lives and the right to autonomy without oppression, discrimination and devaluing as a result of their gender. The devaluing of intuitive knowledge has been argued by Jordan (1993), in her work on authoritative knowledge and the distribution of power by gendered knowledge systems. Jordan's work reflects the historical context of the devaluing of female midwifery knowledge as male dominated obstetrical management of pregnancy became 'normalised' and midwifery became subordinate to medicine and intuitive knowledge became diminished in the eyes of medical science (Jordan 1993; Davis-Floyd & Arvidson 1997). This has resulted in the marginalization of midwifery as a profession in many western countries (Odent 2004).

The work of Harding (1987), Barnes (1999), Lane (2006) and Gould (2008), who describe the historical relevance of a feminist approach to examining empowerment and professional development in midwifery, influenced my decision to use a feminist framework for this study. The underlying assumptions of authoritative knowledge (Jordan 1993) and power relations inherent in that knowledge are that both have belonged to men (Ehrenreich & English 2005). The renouncement of intuition as a legitimate source of knowledge in western cultures occurred for women with the witch hunts of Europe and again for nurses, a gendered profession, when nursing established itself as a science (Munhall, 2012). The attitude that intuition was a feminine, unscientific attribute has resulted in a failure to pursue it as cognition, relevant to knowledge expression until recent developments in brain science. The following section discusses the ethical considerations of the study.

### *Ethical Considerations*

Several ethical considerations were identified during the planning for this study. Ethical issues surrounding the rights, dignity and safety of the participants in the study were considered. The underpinning principles of research; 'diligence, expertise, integrity and honesty', described by Burns and Grove (2005, p. 207) have guided and informed my research. Consideration was given to all aspects of informed consent, confidentiality and

anonymity, which are essential when conducting research, involving humans. The storage of data was also addressed as per UTS ethics protocol (UTS HREC 2010).

Protecting participants from discomfort or distress was important to consider. These ethical considerations are discussed by Burns and Grove (2005, p. 207), in their description of ethical qualities that included: '*self determination, privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm'*. It was important to prepare for the possibility that a midwife may disclose unsafe practises and, or become distressed during or after the interview.

Whilst qualitative interviews may cause some emotional distress, there is no indication that this distress is any greater than in everyday life or that it requires follow-up counselling, although it is acknowledged that distress is always a possibility and needs to be understood and addressed (Munhall 2012). Research that is conducted with sensitivity and guided by ethics can become a process with benefits to both participants and researcher (Smith 1992). The phenomenon being studied is not anticipated to cause distress however the context of birth is a sensitive one and might arouse powerful emotions. Unlike quantitative research where distance and control are valued the qualitative researcher seeks an interactive exchange in which researchers and participants come together to create a context of conversational intimacy in which participants feel comfortable telling their story. It is this context that creates trust and can make the interview potentially therapeutic as well as an essential data collection tool (Munhall 2012).

If a midwife experienced feelings of sorrow, loss, anger or grief during the interview process, a series of actions were necessary. These were to firstly wait, and then provide empathy and support. In my interview experience much of this is done in silence, with the interviewer or researcher sitting and 'being there' for the participant. Once the participant regained composure, she would be given a choice to continue with the topic, change to another topic or question, or terminate the interview. If the participant decided to terminate the interview she would be asked to make arrangements to interview again at a later date. It would not be ethical to leave a participant in a state of distress – as Smith states '*to interview and then leave someone in emotional distress without adequate support or safeguards is morally wrong*' (1992, p. 102). Waiting until the participant had recovered enough for me to leave safely or asking that a friend be contacted to be with the participant was necessary.

If a participant experienced distress or terminated the interview I planned to make contact with the participant by telephone one to two days following the interview to determine if there were any distressing affects still lingering. If there were, I would initiate a conversation about appropriate personal or professional follow-up with a colleague, organisation or counsellor.

In the event that the participants discussed unsafe practises, referral to the Australian Health Practitioners Registration Agency (AHPRA) would be necessary. While this might threaten the trust earned from participants it is appropriate where client safety is at risk (Munhall 2012).

Ethics approval was granted by the UTS Human Research Ethics Committee (HREC) in December 2012 (UTS HREC 2012-393A; see Appendix 1). Data collection commenced in February, 2013. The next section describes the research participants.

### *Research Participants*

Study participants were selected using purposive and snowball sampling. The objective of this method of participant selection is to select information–rich participants who were capable of yielding insight and understanding of the phenomenon under investigation (Bloomberg & Volpe, 2008). Private midwives were contacted by two means. Firstly by placing an invitation to participate in the study with the Australian Private Midwives Association (Appendix 2) and with Homebirth Access Sydney (Appendix 3) and secondly by asking midwives who responded to recommend other midwives who might be interested in participating in the study. The Australian Private Midwives Association is a professional organisation for privately practising midwives. Homebirth Access Sydney is a New South Wales not for profit consumer organisation.

I restricted interviews to Sydney to keep to a manageable distance for time and travel to interviews that were conducted within a one hundred kilometre radius. Inclusion and exclusion criteria were developed to contain the interview process to a current private midwife workforce available within this radius. The majority of private midwives in Australia are practising in NSW. Midwives were selected using inclusion and exclusion criteria.

### *Inclusion and Exclusion Criteria*

Inclusion and exclusion criteria were developed to assist in identifying appropriately experienced midwives practicing within a manageable distance from the researcher. The private midwives selected for interview from within the Sydney locale (within 100 kms of Sydney), were currently registered with AHPRA as a midwife in Australia, had more than three years post-registration as a midwife and attended, as a midwife, more than or equal to five births per year. The midwives also needed to have recency of practice, which I have defined as less than three years since they last attended a birth. Midwives were excluded from the offer of participation in this study if they were not currently registered as a midwife in Australia, practised as a hospital-based midwife and were undertaking or attending fewer than five births per year. The following section outlines the data collection method.

### *Engagement and Data Collection*

Initial contact was made by email with participating midwives and then with those midwives who 'self-referred' after hearing about the study from already participating midwives. Participants were contacted by telephone, asked preliminary questions to determine eligibility for the study, and, if eligible, interview times were organised. At that time my phone number was given for calls/texts prior to the interview. This became an important detail as all the midwives were on-call and attending births throughout the interview process and re-schedules often had to be made at the last minute. Flexibility was necessary, for example, one interview was conducted, at her suggestion, in the midwife's car, at the side of the road, outside the home of a woman in labour after several attempts to interview the midwife had failed.

An information sheet (Appendix 4) was provided to the participants at the time of interview. This document provided them with information about the research process and described their anticipated involvement, assured their confidentiality and the anonymity of any personal information gathered; and how these elements would be monitored and managed (Australian Government 2007). The document also assured them of the opportunity to withdraw from the study at any time without negative consequences.

A short questionnaire was used to collect demographic details (Appendix 6) about the midwife at the time of the interview which included: age, education, type of education, year

of completion, years of experience, type of experience; rural/ urban/ countries other than Australia, type of practice, number of clients annually and collaborative arrangements (See Table 3 p. 51).

The participants were given time and opportunity to ask questions to ensure that they understood the information given to them. Contact details for both my study supervisors were included in the document and both verbal and written consent was obtained prior to commencing each interview (Appendix 5). Data collection comprised of semi-structured interviews and field notes. These methods of data collection will be described and justified in the next section

### *Justification for Interviews*

Data were collected using semi-structured interviews. Semi-structured interviews were selected in order to maximise midwives' narrative around description of the phenomena being studied. The literature suggests that birth stories in narrative form offer a rich and powerful source of data and this finding can, according to Carolan (2006), be extrapolated to midwifery research. In addition, facilitating narrative by semi-structured interviews can obtain specific qualitative information from a sample of the population and general information relevant to specific issues (Carolan 2006). For example, using semi-structured interviews to probe for what is not known has particular relevance for the phenomena of intuition and enabled the researcher to gain a range of insights about private midwives use of intuition.

Social anthropological studies have established a strong basis for investigating female gendered professional structures by an interview process (Jordan 1993; Ehrenreich & English 2005; Fahy 2005; Floyd Davis 2006). Nursing and midwifery research have utilised interviewing in order to capture richly embedded information for research (Lane 2006; Robson 1993; Holloway 2001; Winter 2002). These researchers have used interviews in order to explore concepts that can be revealed through narrative and the participants' reflection on practice. Several authors discuss the importance of allowing the participant time to think and recall during interviews (Cahill 2005; Grbich 1999; Minichello et al. 2004; Munhall 2012; Olesen 1993; Sandelowski 2000; Schneider et al. 2007). This method is recommended to facilitate capturing rich, individual data where a participant is relying on formulating new thoughts. The authors argue that directing and re-directing during pauses

or narrative hesitation will reduce potentially important data. The next section describes the methodology behind the interview process.

### *Process of Conducting the Interviews*

Interview questions were developed that focused on the topic but were broad, open-ended questions that allowed the participants latitude in constructing an answer. The initial set of questions related to the research question and attempted to drill down to the midwife's understanding of the phenomenon being studied.

As the study was conducted using a feminist framework I did not challenge contributions made by the midwives during interviews instead, only valuing their reflections on and evaluation of their own experiences of midwifery and the phenomenon being studied (Opie 1992; Grbich 1999; Steen & Roberts 2011).

When I sought clarification about a statement or idea expressed by the midwife I was conscious to diminish any hierarchical positioning that could be communicated by language, tone and demeanour (Harding 1987). Oakley states that there is *'…no intimacy without reciprocity'* (1980 p. 49). I was exploring a phenomenon of serious interest and commitment to my own work. This assumption allowed me to acknowledge and utilise my own professional and personal past, my 'tacit priori' as a midwife to facilitate the interview process. Oakley (1980) argues that identifying and locating myself within the birthing culture prior to or at the commencement of the interviews should minimise any hierarchical positioning that would reduce the quality of data.

The interviews were audio recorded and manually transcribed by a professional transcription service. The audio recordings of the interviews were sent to the transcriber after each interview to facilitate an interactive and reflexive method for interviewing by conducting interviews and analysis simultaneously (Sandelowski 2000). This process allowed the questions to be developed and modified as the interviews progressed. The audio recordings were loaded into an online platform 'Dropbox' that was accessed exclusively by the transcriber and myself (Dropbox, Inc. 2007). The transcriber provided a signed confidentiality agreement (Appendix 7) and all transcriptions were verbatim. The shared Dropbox was deleted after the final interview transcription. In addition to interview data, I used field notes to provide context and to enhance meaning.

### *Field Notes*

Field notes were collected in order to enrich and deepen the data. Fontana and Frey (in Denzin & Lincoln 1993) describe the importance of four factors contributing to the value of field notes; immediacy (to the interview); writing everything down (recording impressions, hunches, nuance and feelings); writing inconspicuously (if during the interview, to not interrupt the flow of ideas or conversation) and; analysing one's notes frequently. I generated the initial codes by detailed note taking during listening to the audio recorded interviews and again whilst reading the interview transcriptions. I also began making inferences about what the codes meant. I checked these 'big picture' impressions against detailed notes I had made in my notebook immediately following every interview. I began to consider relationships between codes and themes and used a visual model to sort the codes into potential themes. The next section describes the planned ethical storage of the data collected for the study.

### *Data Storage*

The storage of data was addressed as per UTS ethics protocol. The protocol includes the de-identification of all participants, place names and client names in the collected data and requires the safe and separate storage of all audio recordings and hard copy data in locked, secure storage at UTS for a period of seven years (UTS HREC 2010). The next section in this chapter will discuss the ways in which rigour was maintained throughout the analysis.

### *Data Analysis and Synthesis*

Data were analysed using thematic analysis. The following section describes the management, organisation and analysis of the data. Thematic analysis emphasises identifying themes that are patterns across the data that are important to the descriptions of the phenomena being studied and specific to the research question (Boyatzis 1998). According to Sandelowski (2000) two key priorities are involved in analysis, firstly; not to misrepresent or change the voice of the participant and secondly; to perform a thematic analysis in order to bring meaning out of the data. Thematic analysis was performed on the raw data by a process of coding in order to develop themes.

A process of six phases compiled by Braun and Clarke (2006) was used to create established, meaningful patterns. These phases were: multiple listenings and readings of

data for familiarisation, generating preliminary codes, searching for themes among codes, reviewing themes, defining and naming themes and producing a final report of analysis. This method of analysis was selected because it emphasised organisation and rich description of the data for qualitative analysis.

The data were analysed, as they were collected. Sandelowski (2000) argues that simultaneous data analysis and collection is necessary for one process to help shape the other. The data analysis was reflexive and interactive as data collected during one interview influenced what was collected in the interview prior to and after it. This degree of reflexivity assisted in refining the interview questions as the study progressed. Sandelowski (2000) states that there is no mandate to re-represent or interpret the data in any other terms than the participants own however; a degree of analysis is required in order to explore the phenomena being studied and to allow themes around the research question to emerge.

In his seminal work on intuition, Bastick (1993) compiled a list of 20 diverse intuitive descriptors from the 'global' knowledge property of intuition to construct the 'Theory of Intuitive Thought' and argues that these descriptors form a reference for the fundamental organisation of intuition. This study explores aspects of the private midwives epistemology around intuition. The data from the interviews communicate what Sandelowski describes as the 'complexities, tensions and real situational reflections' of the qualitative inquiry (Sandelowski 2000, p. 39). Whilst interviews do not give us direct access to facts, the interview data provided 'real life' (Smith 2007) discourse in the participant's voice and an opportunity to explore the midwife's real, professional life experience. Within the analysis participant quotes are identified by transcript locators to protect anonymity and do not relate to the Demographic Data provided.

The data were listened to, and read, multiple times and the dialogue was scrutinised for themes, consistency and patterns. The process of data analysis in research methods can occur in two primary ways – inductively or deductively (Braun & Clarke 2006). In an inductive approach, the themes identified are strongly linked to the data because assumptions are data-driven (Braun & Clarke 2006). This means that the process of coding occurs without trying to fit the data into a pre-existing model or frame. Similarly, codes were produced inductively in my study by using words used by the participants during their interview. This process assisted with the organisation of the data and increased my research dependability. Alternatively, deductive approaches are theory driven and this form of

analysis tends to be less descriptive overall because analysis is limited to the preconceived frames (Braun & Clarke 2006).

In the following section a description of how thematic analysis was used for this study is presented including Table 2, which provides an example of an initial coding framework.

### *Thematic Analysis*

The data were collected over a seven month period. The data were read multiple times, listened to and examined using thematic analysis in order to distil meaning. This process allowed the significant themes to slowly emerge.

On the following page Table 2 provides an example of the initial coding framework used on the data generated from interviews with four of the participating midwives, exploring their narratives around relationship.

**Table 2:** ***An example of an initial coding framework (Interviews 1, 2, 4, 7)***

| **Raw Data** | **Ideas, Concepts & Emerging Themes** | **Theme** |
|---|---|---|
| I've got a relationship with the *whole* family | relationship | Trust and Relationships |
| They know they can call me, day and night if there's a problem | relationship extends beyond normal professional boundaries | |
| I've birthed seven out of eight children in one family | commitment/longevity/lateral trust across family members | |
| It's not just about that birth it's about the connection over *time* | longevity within a family group experience | |
| It's all about the relationship for me. The relationship and trust | relationship builds trust horizontally experience contributes | |
| Trust is the biggest skill – without trust you can't build the relationship | trust is essential for authenticity | |
| Unpacking the emotional stuff at birth, in labour requires trust | vulnerability: the midwife is vulnerable because she can only work with what the woman gives/ tells her | |
| By the time she births we've done the hard yards in relationship | it can be difficult and takes commitment to build a relationship | |
| You trust them and they trust you. You have a relationship. | horizontal, reciprocal trust. No power base here | |
| You understand what's *normal* for her | sensing normal; it's an individual thing, non-standardised care | |
| It's part of the luxury of getting to know the woman | the midwife feels a benefit from the intimacy, she knows what the woman is capable of | |

In the second stage of analysing the data I listed the words and phrases collected from all the interviews. I then worked through these eliminating any duplication. This had the effect of reducing the number of themes considerably. Once the second, shorter list of themes was compiled I looked for overlapping or similar themes. This process was informed by the analytical and theoretical ideas developed during the data collection and incorporated the notes made in my car immediately following each interview. These themes were further refined and reduced in number by grouping them together if they were at all related. A list of nine themes was then compiled.

After shuffling the data from one environment to another a thematic problem was incidentally solved and the number of themes reduced to two. Sub themes emerged as related to but not inclusive of the more dominant theme sets. I reached data saturation (Munhall 2012) at interview eight and completed four more interviews. Due to time and financial constraints I had ten of the twelve interviews professionally transcribed.

The next stage was to allocate each theme its own coloured marker and work through the transcripts marking all data that fitted into a particular theme by colour. The coloured sections were then identified and labelled for interview identification and section location within the transcription. Finally, I cut into the transcripts removing the sections of data for each theme and pasted them onto spreadsheets to assist with managing the large amounts of incorporated data. These data sets were then filed according to colour and code with a report and notes and ideas that occurred to me during the process. This reduced list formed the final thematic system used to divide up all the interviews and explore the data for meaning and patterns. I chose to handle the material manually because of the relatively small number of interviews involved. I attended an NVIVO (research software for qualitative data analysis) workshop in anticipation of using it for data management however once I had started the process 'by hand' I found I enjoyed the physical relationship with the data and proceeded easily. A discussion about how I sought verification of the analysis follows.

### *Verification*

It is a common belief amongst social scientists that a definitive, objective view of social reality does not exist (Berg & Lune 2013). Consequently some researchers have claimed that qualitative accounts cannot be assumed to represent the social world and therefore

different researchers may interpret the same data differently. This raises the issue of the verifiability of qualitative data analysis. The literature describes two key ways to have data analysis verified; respondent validation and peer review (Berg & Lune 2013). I chose not to do respondent validation because in the time after participating in the interview, participants may have formed ideas or changed their views and perceptions about the phenomena under investigation. This was a concern because of the temporal and cognitive effect of raising their consciousness about intuition as a result of their participation in the study. The simultaneous collection of data with systematic thematic analysis combined with seeking verification by peer review assisted in maintaining rigour throughout the preparation of the study.

### *Maintaining Rigour*

In this section demonstration of the value and integrity of my research is given by drawing on the work of current authors in the field.

The demonstration of rigour in qualitative analysis relies on the researcher showing that they have examined the data wholly and adopted a clear, thoughtful and reflexive position when evaluating their research (Finlay 2006). The three concepts of reliability, validity and generalisability provide a basic framework for conducting and evaluating traditional quantitative research (Silverman 2010). However, some current authors encourage the qualitative researcher to move away from these positivist criteria in order to critically and meaningfully evaluate their research (Bloomberg and Volpe 2008; Silverman 2010; Finlay 2006; Savin-Baden & Fisher2002).

Reliability (the consistency of the means of data collection) might be questioned in my research, as what emerged from the interviews was contingent on my approach and the specific interviewer-participant relationship, context and timing. It is unlikely that another researcher, or even myself, interviewing the same participants again could elicit the exact same ‘story’ or capture identical data. This was evident during the interviews when it became apparent that most of the participants had never thought about the process of intuition. The introduction to the topic of intuition may have altered their thinking, therefore influencing the data that could be captured subsequently. The flow on effect of this in a small cohort is that the participants may have influenced their colleagues thinking and awareness, which may have changed the data collected.

Validity (the degree to which research truly measures what it was meant to measure) rests upon the assumption that the phenomenon being explored possesses 'reality' in an undisputed, objective sense. Given the diversity of the social world and the complex nature of thought processes over time there cannot be one unequivocal reality to which all findings respond. My research necessarily involved subjective interpretations by both the participants and myself as the researcher. These could not be excluded from the research process and it follows that my analysis can only be presented as tentative description of a field of limitless interpretations.

Generalisability (to extrapolate statistically, findings from a specified sample to the wider population) is irrelevant and impossible in relation to this study. The richness and depth of data obtained from just one participant who has been purposely approached has stimulated findings and provided deep discussion that is not readily transferable, nor necessarily relevant to a broader population.

For the purpose of this study I implemented Finlay's four dimensions of evaluation; clarity, credibility, contribution and communicative resonance (Finlay 2006). By selecting these evaluative criteria I was able to conduct the study in a logical and coherent way. In terms of clarity the research was evaluated by asking whether the study made sense, was systematically worked through and was coherently and clearly described. Credibility was assessed by the extent to which the findings matched the evidence and whether they were convincing. I also continuously assessed whether the interpretations were plausible and justified so that readers could see what the researcher saw even if they drew different conclusions from the study. In terms of contribution, the research will be evaluated for its empowering or elucidative information and whether it offers an interesting basis for further research. Communicative resonance will be evaluated by judging whether the findings are sufficiently engaging to interest readers and whether the research contributes to discussion within the wider academic community.

Working in a systematic manner has enabled a demonstration of concern for trustworthiness and rigour as well as ethical integrity. Informing these aims has been the continuous use of reflexive discussion in order to link the evaluative criteria to epistemology. In the following section I explain how I have situated myself within the research and what led me to this study.

### *Situating Myself Within This Research*

As described previously, in Chapter One, during a thirty year practise of midwifery, a combined interest in midwives and intuition, the birth environment, and developments in brain science, has led me to this study. My involvement with midwives and midwifery students has contributed to my personal evolution from practising midwife to researcher. I have become particularly interested in the skills that some midwives draw upon in what can be described as the space between formal learning and their experiential learning. I have observed midwives draw upon a private, 'inner knowing' that has not been taught or consciously learnt, that represents their intuitive knowledge. I have witnessed my own beliefs about intuition shift in response to my exposure to neuroscience and brain theory.

A further development in my understanding has been stimulated by discussions with peers and through personal reflection about knowledge acquisition, intuition and the politics of 'knowing' how to work with women in childbirth. In an attempt to explore these issues further and blend research enquiry with midwifery expertise, I have undertaken graduate studies. These studies have not only afforded me the opportunity to satisfy my own quest for life-long learning, but also provided me with the opportunity to investigate what I consider to be a core epistemological issue, the evolution of midwifery perspectives on teaching and learning about intuition. These perspectives are fundamental in that they both serve as our compass and define our practice. Because of this, I set out to explore the impact of intuition on midwifery practice. Meeting this objective has already begun to inform and deepen my own practice. The following section describes my use of reflexivity during the study.

### *Reflexivity*

Reflexivity recognises the circulatory relationship of the researcher to the data, the data to the participants and the participants to the researcher (Munhall 2012). This is important because the researcher needs to be aware of their role in the analysis of the data and remain sensitive to meanings and patterns that may emerge. Munhall (2012) describes the important influence relationship and communication between the researcher and the participants have. The influence of each component of the study on the knowledge produced by the study is as important as the reflections on the process, actions and observations during the study. It is important to note that throughout this inductive process, I remained conscious of my theoretical epistemological responsibilities.

For qualitative researchers, the evaluative criteria need to *'acknowledge that trust and truth are fragile.... while enabling them to engage with the messiness and complexity of data interpretation in ways that... reflect the lives of...participants'* (Savin-Baden & Fisher 2002, p. 191). To this end, I have attempted to be clear and explicit about criteria that add to the transparency of the research, enabling the reader to better understand my values and interests. I have engaged in the research reflexively in order to present an accurate, trustworthy and relevant study that demonstrates rigour. This has meant that I have sought for negative instances in the participants' dialogue rather than selecting only anecdotes supporting my interpretations to avoid merely a subjective assertion supported by unscientific method. I have aligned my research to Finlay's call for qualitative studies to be judged on their ability *'to draw the reader into the researcher's discoveries allowing the reader to see the world of others in new and deeper ways*' (Finlay 2006).

Feminist nurse researchers have pointed out that ethical dilemmas arise when doing research in one's own professional culture, where the researcher and professional roles may conflict (Olesen 1993). The term intersubjectivity is used by Smith (1997) to emphasise the importance of shared cognition and consensus that is essential in the shaping of our ideas and relations. It moves our understanding away from a focus on the individual mind and toward participatory aspects of social understanding. Working within a feminist framework there is an assumption of intersubjectivity between the researcher and the participants and the creation of data (Harding 1987). Olesen suggests that incorporating adequate reflexivity into the research is necessary to avoid "subjectivity" and distance from the participants and to encourage consultation and collaboration with participants when engaging in data gathering, analysis and writing. This was a potential issue for the proposed study. Olesen (1993) argues that collaboration is essential when working within a feminist framework where women's knowledge is captured in order to minimise or reveal contradictions in power and consciousness.

Smith's (1987) work suggests a high degree of reflexivity is required from the researcher and also recognises the feminist framework. Smith blends Marxist, phenomenological and ethnomethodological perspectives to discuss the importance of intersubjectivity in qualitative research. Aware of women's exclusions and silencing in many organisations, including academia, she conceptualises the everyday world as being continually created, shaped and known by women within those organisations. Smith (1987) argues that the researcher herself must not create a distance from a world that is an object of study but

rather the researcher should locate herself within the context of the study and be aligned with the strategies of thinking and inquiry. As I am both female and a midwife familiar with the role of the private midwife, my insight into these mechanisms and the potential issues relating to subjectivity and organisational hierarchical attitudes should not present a barrier to alignment with the participants. However, reflecting on this issue leads me to acknowledge my own bias regarding organisational hierarchies in particular. The effect of organisational hierarchies on the midwives in this study may come to light. Organisational hierarchies are not the focus of the study however should discussion around this issue occur it will be analysed within the feminist framework of the study.

Whilst Smith (1987) and Olesen (1993) argue forcefully regarding intersubjectivity, Burns et al (2012) discusses the need for researcher awareness about 'insider' knowledge. Burns argues that whilst insider knowledge facilitates interview and analysis, an ability to ensure an analytical degree of distancing will be required (Burns et al. 2012). For this reason I endeavoured to conduct the interviews from the perspective of a 'research midwife'. I have become increasingly aware of the influences that my own beliefs and views could have on the research topic and how this might affect the research study (Steen & Roberts 2011). As a result I have maintained a high degree of reflexivity throughout the research process and, at regular intervals, considered how my beliefs and views may be influencing the study in order to reduce personal bias (Steen & Roberts 2011). It has been important to separate bias from alignment (Smith 1987).

## Summary

This chapter has demonstrated that a qualitative descriptive research methodology was suitable for exploring Australian private midwives' use of intuition and their understanding of the phenomenon being investigated. The chapter began by examining different authors' description of qualitative research. The behavioural origin of a descriptive qualitative methodological approach and how this approach assists to understand complex human behaviour was then discussed. How the study was developed to achieve its purpose and why this approach was selected to answer the research questions was identified.

The following section defined intuition and described the brain processes of information synthesis and provided further background to the study's methodological emphasis. The

section ‘Intuition as Knowledge’ argued that intuitive knowledge is an accepted epistemology that assists scientific investigation.

Standpoint theory and the work of other feminist researchers were incorporated into the description of the study’s feminist framework. The use of feminist theory was used to examine the marginalisation of private midwives and the diminishment of intuition as a legitimate source of knowledge. The chapter then identified the study’s ethical considerations and issues surrounding the rights, dignity and safety of participants were examined. The research participants were described and the inclusion, exclusion criteria were identified. The next section described the engagement of participants and the methods of data collection used for the study. A justification for the use of semi-structured interviews was discussed using both feminist and qualitative researchers. The process of conducting the interviews was described and the use of field notes in order to enrich and deepen the data was justified.

Data storage, data analysis and synthesis were examined and the process of simultaneous collection and analysis was presented. How rigour was maintained throughout and the value and integrity of the study was demonstrated. A section situating myself within the research identified my own professional background that led me to engaging in the study. The final section discussed the thinking and inquiry necessary for insightful reflexivity to be incorporated into the research process. The study’s findings are presented in Chapter Four.

# Chapter 4

# FINDINGS

### *Introduction*

The purpose of this qualitative descriptive study was to explore 12 private midwives' use and understanding of intuition in their practice. This chapter presents the key findings obtained from the semi-structured interviews.

The chapter is comprised of two main sections. In the first section the study participants are described and their demographic data is displayed in Table 3. The midwives' demographic data is followed by a Diagram of the Themes, displayed in Figure 1. Following the diagram, I have included a section where the midwives explore their understanding of intuition. None of the midwives had any formal knowledge about intuition and its history and they expressed little or no understanding about the cognitive existence and development of intuition. My exploration of their description is presented under the heading 'Midwives and Intuition' and has been placed apart from and separate to the findings because their insight is unique both culturally and professionally and represents new understanding in an Australian midwifery context. This information prefaces the findings and has been given significant attention as it affords us an understanding about the midwives themselves, their cognition and experience, and provides important insight into the phenomenon under investigation. The second section comprises the findings and the two themes that are presented and illustrated with the participants' transcribed dialogue. The chapter concludes with a summary.

Ultimately two themes emerged from the analysis of the data. These themes related directly to the study's research questions that were: Do you use intuition in your midwifery practice? And: What is intuition and how do you use it? The two themes were: Trust and Knowledge. Within these themes, related sub themes were identified.

The findings are presented by using quotations from the data. The first major finding that emerged from the data was that the midwives all reported using intuition when attending women antenatally, during labour and birth and in the postnatal period. Whilst integrating intuition into their practice, none of the 12 midwives had considered what intuition was prior to the study interviews. The midwives expressed their own ideas and beliefs about their intuition, had complete confidence in its value for their practice and an absence of

understanding about the origins of their own personal intuition. Their ideas about intuition were sometimes similar and sometimes very different to their colleagues. The second finding was a commonality in the midwives' descriptions of how they used intuition in their practice especially whilst caring for women during labour and birth. By using the participants' own words I have sought to accurately represent the reality of the midwives experiences and the phenomenon under investigation.

All the midwives considered intuition necessary for exemplary midwifery practice and relied on its perceived accuracy and contribution to problem solving for their practice. The interviews demonstrated that the midwives had incorporated intuition into their practices in complex and sophisticated ways and were fluent and sometimes funny in their descriptions of their experiences of intuition. They all conceived their use and reliance on intuition as 'normal' and unexceptional. A description of the study participants follows.

### *Study Participants*

The 12 midwives were between 33 and 70 years of age and all were women (Table 3). They had all undertaken their midwifery education in Australia and had been practising privately for between 3.5 and 27 years. The midwives worked in a variety of models of care. Seven worked alone but had personal and professional networks that provided support. Two worked both alone and as part of a private midwifery group practice and two worked exclusively in a private midwifery group practice. One midwife worked as part of a team practice of two midwives. All had a professional relationship with a practising obstetrician at the time the study was conducted. Regardless of the model of care, the midwives assisted the women in their care to plan to give birth at home. Where necessary, they would transfer a woman to hospital and, if possible, would assist her to give birth in the hospital. The midwives all practised within a continuity of care model where the midwife maintains the clinical responsibility for the women who seek out their care during pregnancy, in labour, for the birth and for up to six weeks after the baby are born. Two also worked on a casual basis at metropolitan hospitals in the obstetrics department.

Of the six midwives who held Hospital Certificates in Midwifery, three had undertaken further tertiary study gaining Masters Degrees in Midwifery. Four had sought and been awarded endorsement as Eligible Midwives by AHPRA. Two were in the process of studying by distance education to achieve endorsement as Eligible Midwives.

Practice sizes varied, with midwives attending between five and forty clients per year. Some midwives were in the process of developing their practice and others were trying to scale down. One midwife was 'closing her books 'after more than 20 years in private practice. All the midwives were responsible for conducting their private homebirth practices as a business. They were all awaiting legislation regarding professional indemnity insurance for attending births. They had all worked continuously in private practice apart from breaks to have their own babies and to take holidays. All midwives described their work as important for women, families and the community they lived in. All expressed a strong internal locus of control due to the autonomous nature of their practice. They all described their work as a vocation rather than a job. Table 3 displays the midwives demographic data.

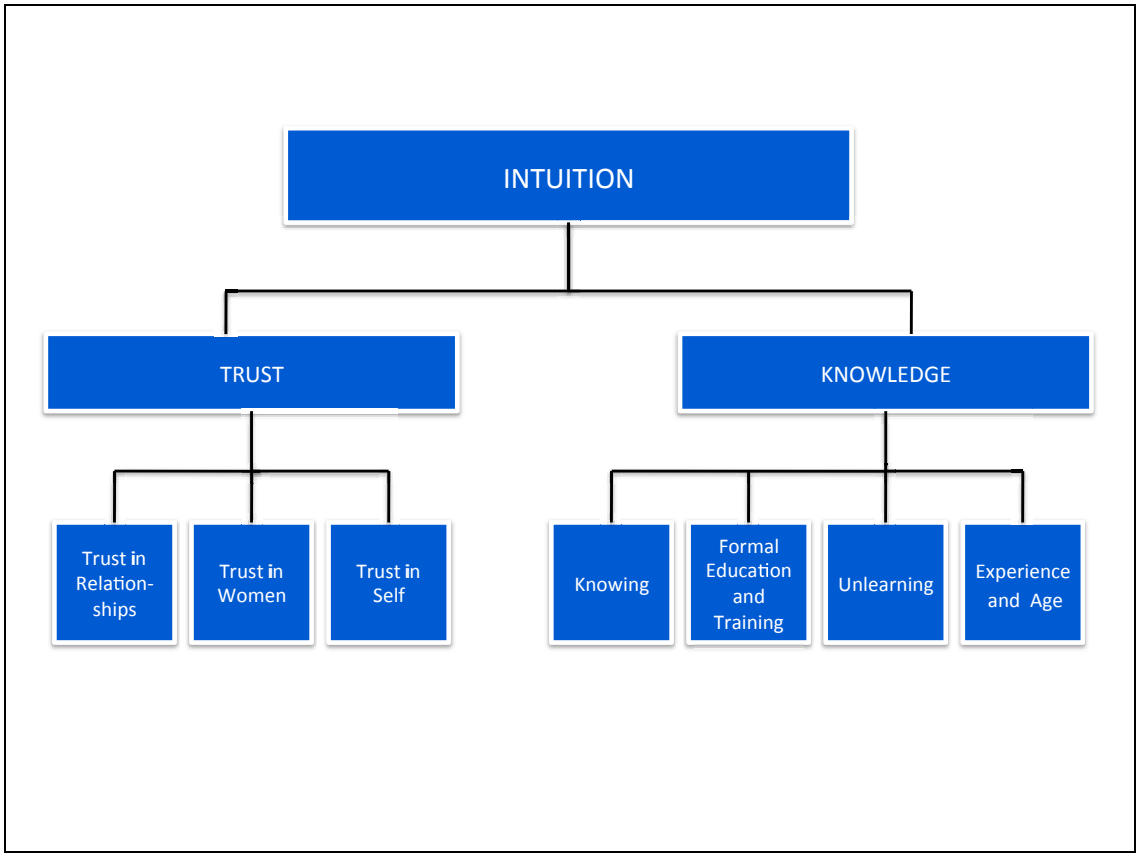
**Table 3:** ***Demographic Data of Study Participants***

| Number of participants | Age Range In Years | Years in Private Practice | Solo or Group Practice | Number of Clients Annually | Midwifery Education | Year of Completion of Midwifery Education | AHPRA Endorsed as an Eligible Midwife |
|---|---|---|---|---|---|---|---|
| 1 | 40 - 50 | 3 - 5 | solo | 30-35 | B Mid | 2005-2010 | No |
| 2 | 30 - 40 | 3 - 5 | group | 8-10 | Grad Dip | 2000-2005 | Yes |
| 3 | 45 - 50 | 20 - 25 | group | 30-35 | Hospital Certificate | 1985-1990 | Yes |
| 4 | 35 - 40 | 5 - 10 | solo | 20 | Grad Dip | 2000-2005 | No |
| 5 | 65 - 70 | 20 - 25 | partner | 5 | Hospital Certificate | 1960-1965 | No |
| 6 | 45 - 50 | 3 - 5 | solo | 20 | B Mid | 2005-2010 | Yes |
| 7 | 30 - 35 | 3 - 5 | solo | 28-30 | B Mid | 2000-2005 | No |
| 8 | 50 - 55 | 15 - 20 | solo | 35-40 | Hospital Certificate | 1980-1985 | No |
| 9 | 60 - 65 | 10 - 15 | solo | 18-24 | Hospital Certificate | 1970-1975 | No |
| 10 | 40 - 45 | 3 - 5 | solo | 25-30 | B Mid | 2005-2010 | No |
| 11 | 55 - 60 | 25 - 30 | both | 10-30 | Hospital Certificate M Mid | 1980-1985 | Yes |
| 12 | 50 - 55 | 25 - 30 | solo | 6-12 | Hospital Certificate M Mid | 1985-1990 | No |

NB: age and year ranges have been provided to protect the anonymity of participants.

Within the text, participant quotes have been identified with narrative locator numbers. These numbers appear in brackets following the quotes and are coded to be unidentifiable. On the following page a diagram of the themes that emerged from the data is displayed in Figure 1.

**Figure 1**: ***Diagram of Themes***




The themes of trust and knowledge were integral to the midwives experience of intuition. Their description of trust had three components; trusting the relationship they established with the women in their care which involved true and honest communication; trusting the women themselves which included issues of control, fear and truth and; trusting their own intuition which demanded confidence and experience. The midwives described four aspects of knowledge that underpinned their intuition; a sense of 'knowing' and certitude about a situation; their knowledge and skills learnt during their formal education and training; the need to un-learn institutional attitudes about women and normal birth, learning new relational skills and re-establishing a belief in normal labour and birth and; knowledge that resided within midwives who had matured as women and practised as midwives for many

years. These will be further described later in the chapter. In the following section, the midwives describe their personal understanding of intuition.

### *Midwives speak about intuition*

The midwives spoke about intuition from a 'lived experience' and 11 of the 12 reported that whilst they relied on it to practise midwifery they had not previously thought about what it was, its origins, how it emerges and where it is located within or outside the body and brain. All had difficulty articulating their understanding of intuition and this was reflected in frequent pausing, sighing, re-directing and faltering that characterised the verbatim transcripts when the midwives described intuition. These features of narrative speech are identified by Silverman (2010) as indicators of difficulty. Ten of the participants exhibited 'difficulty' in this way when describing intuition. Nevertheless, the midwives tried to articulate their thoughts about what they were doing cognitively and what was occurring physically when using intuition as highlighted in their quotes.

### *'... the consciousness of my skin'*

When asked about intuition, one of the study participants, a midwife for more than 25 years, thought for a moment then laughed, *"That's easy. Its knowing what adrenaline smells like, what fear sounds like, what a lack of desire looks like. It's the consciousness of my skin. That's what it is"* (1005).

This description encompasses a 'whole body' view of intuition that was similar for all the midwives. However one participant expressed that she had thought about intuition prior to being interviewed. She expressed it in this way:

> *When I think about intuition, I think about, what the hell is it? And I don't know. I don't think we can define it. I think it's just something that hits us. And if we can listen to it, for whatever reason it's not always going to be a hundred per cent, and sometimes you go, "No. Don't know what that was about. But when it does work for you, you go, "Yeah, hell. That's great*". (1007)

The midwives experienced intuition differently and attributed its origins to physical, emotional, cognitive and spiritual domains. However all the midwives felt that it always involved the senses and a 'consciousness of skin'**,** which translated as a visceral experience. As one midwife put it:

*I don't know because I've never thought about it until you've asked me. I don't know. Ohhh it's just really hard to articulate. It's like trying to describe love. For me, it's a physical, sensation. Oh, probably everywhere but it probably feels more physical. (1005)*

Another midwife described it as a presence she experienced rather than something she thought about and made conscious:

*Intuition? It's like a shadow. It's there but it isn't tangible. I can't get it out and read it. I have to feel it. (1008)*

Two participants spoke of intuition occurring in their 'gut', for example:

*Usually it's a gut feeling. Or just thinking outside the box a little bit and well, this isn't working or that's not working, what's the solution that's going to meet everyone's needs without necessarily falling into a structured, predetermined plan. And then just giving it a try. Without necessarily knowing, yes it'll work or no it won't work. (1001)*

The same midwife did not connect intuition to previous experience, saying:

*I don't know. I wouldn't say experience because it's often things that have come up just for the first time and you've got an intuitive feel about what needs to happen or what should happen. Sometimes it maybe comes from experience. But mostly it's just a sense that you get. A sense that you get that's not based on experience and previous things. Don't quite know how you'd define it. (1001)*

Several of the midwives however did relate intuition to experience and felt that it developed more as their midwifery experience increased. Other midwives believed their intuition was associated with their 'femaleness' and were aware of it before and apart from their midwifery practices. One was aware that her intuition had developed over time and that it served a purpose in monitoring situations that required different skills to her clinical ones. She felt that her clinical skills were insufficient for understanding and resolving all situations. This midwife differentiated between obvious clinically- driven assessment and assessment using subtle information derived from her intuition. She expressed it in this way:

*What do I think my gut intuition is? For me it's a warning system, if something doesn't sit right for me. And I, I just had that uneasy feeling, then it's what*

*encourages me to look, more, into a situation. Sometimes there's something subtle that's wrong. That your clinical skills aren't up to. They can't detect it, you know. Something else is working it out. (1004)*

The same midwife thought that fear and intuition were linked. She suggested that bad birth experiences have developed her internal warning system, saying:

*I think sometimes its fear. And maybe your experiences can make you more fearful. I think its purpose might be, to guide you maybe between what's safe and what's unsafe or, or to explore something a little more... definitely for me to be based on fear – for me it's not a conscious thing. It just, happens. It's not something I can intentionally search for ... I can't pull it out of myself if it's not there. It just occurs. Either a feeling comes or it just doesn't. (1004)*

Seven of the midwives thought of themselves as very intuitive before practising midwifery. Those midwives reported relying on intuition in every aspect of their lives. Five reported that their intuition had developed as a consequence of their practice as midwives. They believed intuition was part of 'women's business' that was drawn out of them once they began working within the intimacy of women's lives. One midwife expressed the difficulty of separating the components of her formal knowledge about women and birth and her experience of women and birth in this way:

*I think it's internal. I think it comes from in you. In my conscience. I'd say. I guess some intuition would have to have a bit of knowledge to know what the intuition ... Like, what – No. I don't know – No, I don't. I truly think that I'm intuitive of things, just me. Just, just ...You know, I'm, I'm, learning and doing and, and I tend to, um just ... Rely on my intuition ... (1005)*

The midwives grappled with intuition as a form of knowledge. This may have been because they largely described it as a visceral experience and found it difficult to attribute a cognitive element to a physical sensation. One describes her intuition as "*knowing what her eyes can't see*". This reference to trying to bring into conscious thought what they are relying on unconsciously was shared by all the midwives. She demonstrates the difficulty in this way:

*And sometimes I think to myself, Is that intuition? Or is it, your, knowledge and ... and a number of things, happening, that, you know, in your subconscious. Or is it, just, a knowing? I think we're given those, feelings whether it's...you know people*

*talk about the "gift of fear", where, you just know. I think it is something that exists in all aspects of life. I think trust is an issue. (1006)*

This midwife explained the difficulty of perception. She was unable to isolate intuition from knowledge. I asked whether that was because intuition is knowledge. She explained:

*I would say...initially, but then that brings up that question again, Is it...? How much of that, is knowledge...? I don't know if you listen to a fetal heart and even though its within ...normal baseline and you tick all those boxes. If you have a feeling that something's not right is that because, you've listened to hundreds of fetal hearts and this one is slightly different in such a subtle way, that you can't put your finger on it? Or is it, that you just know something's not right? Something you can't see with your eyes. You know? I don't know. (1006)*

However another midwife who has been practising for more than 25 years did attribute a cognitive element to her intuition:

*I think there's two sides to the brain, working all the time. I'm watching the woman. How far apart are those contractions? And how is she reacting to them? And is there any blood loss? Her blood pressure's normal and she's afebrile and all these medical-type things are, going along OK. And so on paper this is looking all OK. But then I start to listen to that other little voice that says there's something not right here. (1002)*

She wondered whether her cognition and intuition were influenced by experience, saying:

*Sometimes something's not right that you can never put your finger on. And so I've actually learnt to trust that more. It's that intuition that's just, there in your head. Is it there because I've seen so many births...Or been in this situation before...? (1002)*

Another midwife was sure that intuition was knowledge that can be learnt until she began processing her thoughts whilst speaking. This is an example of the conflict experienced when cognitively framing a behavioural experience of doing, sensing and remembering things whilst using our conscious minds. She made a plausible case and then reviewed it whilst she remembered her experiences as she explained:

*I think the skill is to learn intuition. I think patience and, knowing, the knowledge of, a woman's body. The knowledge of birth. Knowledge of, not normal ...All need to be nourished and, and you need a good hold on all of that for your intuition to actually*

*be fully functioning. I think it's always there. I think intuition is always there. But I think how to hold it properly is learned.... I think a lot of it is knowledge ... No – I don't think its knowledge. I think you need to know knowledge, for intuition to work. I don't think intuition is knowledge. (1003)*

One midwife was very definite that intuition was not a cognitive function but instead had a metaphysical origin. She expressed it this way:

*No. It's not knowledge. It's a sense. It's maybe more spiritual or more emotional but it's not in the thinking, analytical, knowledge domain. (1001)*

One midwife considered that intuition was a brain and a heart function where physiology and cognition are perceived as separate functions that relate during intuition. She said:

*In the brain.Yeah. And some of it comes from the heart as well ...I don't know where it comes from but something deeper comes out and you think, "OK. Alright. I trust that intuition. I trust that that's what my brain is trying to say ..." (1009)*

The midwives were conflicted about the origins of their intuition but not about its occurrence in connection to relationship. Where they had opportunity to get to know the women and their families they experienced more intuition about the woman and about ways of helping her, both physically and emotionally, especially during the labours and births. Another participant described intuition as a bi-product of knowledge, an interaction between what the brain has learnt and the emotions involved in a relationship with the women in her care. She stated:

*It's probably a bi-product of knowledge. So, the knowledge that you have around that woman, then, can help you gain intuition as to what's happening for her. More than anything. I think. So knowing the woman – informs my practice and intuition (1003)*

Although the midwives experienced difficulty answering the question 'What is intuition?' they reflected, processed, remembered and described their thoughts and experiences in order to answer the question. Their experiences of intuition contributed significantly to their confidence in their midwifery skills and their acceptance of intuition as integral to working with women. Their confidence in their intuition was undiminished by a lack of knowledge about it. This chapter now moves onto the main themes that are connected to their understanding of intuition.

## MAIN THEMES

As described earlier, two themes emerged from the data, they were; trust and knowledge. The midwives repeatedly linked their intuition to the fundamental importance of trust. This was expressed by all the midwives and emerged as the strongest theme. Within this theme they talked about three aspects of trust that influenced the prevalence of intuition, they were; trust residing in their relationship with women; trust in the women themselves to take responsibility and make informed choices; and trust in their own midwifery knowledge and skills which included trusting their intuition. The second theme was knowledge. Knowledge was described in four ways; as knowledge gained through formal midwifery education and training; social and cultural knowledge learnt or modelled from within the institution that created a negative bias toward normal labour and birth; these attitudes and bias had to be un-learnt when the midwives began working privately; and knowledge that developed through many years of practice and had elements of wisdom attached to it. The first theme to be discussed is trust.

## TRUST

### *'They trust me and I trust them': Trust and Relationship*

The first and most significant theme to emerge during analysis was the concept of trust and relationship. This concept was integral to the midwives description of the environment that contributed to their access and use of intuition. Without midwife and woman client relationships based on reciprocal trust, midwives experienced less intuition in their practice. The development of trust in the relationship between a midwife and the women she cared for emerged as a strong theme in the study findings. One midwife described intuition itself as trust:

> *I think it's held up by all of these other things that you need to learn about and know about and how, how to hold ... For intuition to actually function. Intuition is ...I don't know. Trust.They trust me and I trust them. (1007)*

The midwives' conscious attitudes towards birth were that it is a normal, healthy state for most women and a normal life experience. They expressed the view that normal labour and birth could be long and arduous or short and easy at times complicated by both physical and emotional factors yet remain normal. The midwives uniformly expressed that

pregnancy and birth were considered normal until they proved otherwise. They fundamentally believed that the role of the midwife was to assist the pregnant woman as required and to provide an empowering presence. Whilst they acknowledged that they needed their clinical, formal skills to practise midwifery they all expressed the belief that their interpersonal skills were dominant when caring for women antenataly and during birth. The midwives rejected the ownership of birth by anyone but the woman herself and felt that their own autonomy reflected the women's autonomy and control over the processes of her body during childbirth. This was seen as 'women's work' and formed part of the feminist culture and language used to describe their midwifery practices that focused on 'the woman'. A midwife described the relational aspect of being a woman working with women in labour and illustrated the importance of knowledge about women and birth in this way:

> *It's much more about the sounds of women. Being able to just know where they're up to, in their labour. You can often see someone who you might have discussed some fears that they may have had, and how that manifests itself in their labour. In their progress, or with, how they respond to what's going on around them. Just being very much aware of that environment around them. And the people that they've got there and what works and what doesn't work. Being able to just watch them follow the processes of their body a lot better. I think that's the first component. Is just, being present. And that is part of the learning of...intuition. (1007)*

The midwives also believed that women could embrace and trust in the right environment with a care provider with whom she had formed a relationship. Forming relationships was also seen as 'women's work', something that women hold as important and do throughout their lives.

The midwives placed importance on the value of truth and honest communication with the women in their care in order to build trust that reduced fear surrounding birth. One midwife linked professional accountability to building relationships with women in her care. She highlighted the impact that every interaction can have on a birth outcome and the woman and her family's future psychosocial health. She emphasised the difference between medical attention and midwifery care:

*Doctors consult around fear. But as midwives we have accountability too. Our language. Our body language. Our respect. Our support. Our connection. It's our care. It's our relationship. We need to have an awareness of what we do today for the future of that woman. You have an opportunity to build that relationship and if you don't do it well, you haven't got the relationship with that woman. (1008)*

The same midwife expressed the idea that practitioners were accountable if they failed to establish relationships with women in their care. She linked a failure to be able to form relationships to the need to rely on technologies to manage women during childbirth, explaining:

*Then you haven't got the ability to really provide care at the level that you need to. Because if you really genuinely have a relationship with someone, well, you really care ... and you won't be relying on machinery. And we know how well that works don't we? (1008)*

Another midwife emphasised the disconnectedness of care and care providers. She felt that trust was dislocated when women saw several care providers or negotiated care with more than one institution during her pregnancy. She expresses it in this way:

*Trust. That's the intuitive stuff. It is about relationships. It's about knowing them. And we get that opportunity because that, ultimate trust is about birth and to allow us in there as women, to women. The trust is dislocated all the time. We keep disrupting it. Changing rules, policies, changing practitioners. Changing hospitals etc. Changing specialties and care providers. Changing ... You know. (1005)*

One midwife believed the knowledge she gained about the woman during pregnancy was dependent on a trusting relationship. She described a labour in which the woman's grief about her recent separation from her partner came up during her labour causing it to stall:

*But then she just shut down. I watched ... I waited for ages. The smell of labour left her. She wasn't connected to her body. She just sort of stopped. She sounded different. (1007)*

Her relationship with the woman, developed through honest communication and trust of each other informed her practise and actions. She described it in this way:

*... four hours passed. Nothing. I closed my eyes and went over our antenatals. I don't know how long I was doing that. She went outside for a while – the contractions had*

*stopped. Still, nothing, you know. I got this really strong notion. It was so persistent. I waited a bit just to really feel it, you know. Five hours, nothing. Still no contractions. (1007)*

Because of the relationship they had developed in pregnancy she was able to know intuitively what the woman needed in order to 'unblock' her emotions and help the flow of hormones that stimulate contractions. She described the effect of following her intuition in order to assist the woman's labour to progress:

*Then I went over to her and just ... without speaking ... just ... you know ... stroked her hair first, then slowly put my arms around her. We just stood, me holding her. So long, you know. She was crying and crying. I think about half an hour? Just standing together, crying ... then, really quite suddenly, strong contractions, eye contact with her Mum, sounds, noise, smell, all the ... everything, you know ... away we went ... baby born fifteen minutes later, tops. Bam! Thank you. Too beautiful. She just needed to cry the grief out before being ready for the new baby. Fantastic ... eh? (1007)*

Although trust was described as fundamental to relationship, trusting the woman's knowledge of herself and her awareness of her own physical, emotional and social needs was also important to the midwives interviewed.

### *'I need to trust my intuition about them too': Trust and Women*

Several midwives expressed the idea that they needed to develop relationships with women in their care in order to develop their trust in the women. A less experienced midwife put it this way:

*Don't get me wrong. I love women; I spend my life working with them. But, they don't always make good choices, you know? I want to trust them. But I need to trust my intuition about them too. (10010)*

Several of the midwives explained that trusting the women in their care occasionally became an issue during labour. Many of the midwives attended births without another midwife present and expressed the idea that they were vulnerable both personally and professionally when attending women privately, at home, alone. A very experienced midwife disagreed with the idea that midwives might decide to terminate a contract with a

woman due to issues of trust. She considered not trusting women as institutional and patriarchal behaviour:

> *No. That's fear. We are there to support them [the women].We aren't there to control things. That's what hospital is for. These women don't want that. Women need to trust each other. If you're afraid of a woman get back up but don't give in to fear. That's a dead end. (1008)*

The midwives described the fundamental importance for the woman to trust the midwife as a prerequisite for disclosure of potentially important information during the pregnancy. This information was often psychological in nature and all midwives reported the profound influence that a woman's emotional state could exert on a labour. However some midwives emphasised the necessary reciprocal requirement, that the midwife should feel she can trust the woman. This did not relate to issues around disclosure and information sharing but instead related to the midwife feeling confident that the woman in her care would accept her advice regarding care, management and transfer to hospital. Two midwives described experiences where they had to confront a need to protect themselves professionally where they had lost trust in the woman in their care. One midwife described having to terminate the contract because her trust in the woman was eroded during the pregnancy rather than developed:

> *After a bad birth and ten years doing this [private midwifery] I finally got the ovaries to say to a woman "Sorry, but I can't continue with you. You'll have to find another midwife". It wouldn't have worked. It was too scary. I didn't trust her anymore. (10011)*

As a result of these experiences and in collaboration with their professional support group, those midwives now practised with a requirement to feel that they could trust the women in their care personally. This sometimes became manifest during labour when the midwives wanted to transfer their clients to hospital in the absence of clinical reasons. Without a clinical reason to transfer, the midwife was relying on the accuracy of her intuition. These midwives spoke about the importance of the territory of trust and an agreement regarding the midwife's advice about transfer to hospital being negotiated during ante-natal visits. All midwives reported that fear diminished intuition. Midwives described the influence of their own fear on a woman labouring at home and the need to determine what their fear was in order to prevent it interfering with their intuition.

Two midwives spoke about clients who were in abusive relationships and wanted to maintain control over a domestic situation or, protect a fragile relationship from the stress of hospital or institutional scrutiny. One midwife describes an experience she had:

> *In the end I stayed with her. Because she could control things at home, you know? Keep him happy. She knew how to do that. I just felt so sorry for her really. If I didn't stand up with her, how bad would that be? I knew she could handle anything birth handed her because she'd handled everything with him for a long time. It was her choice. So I stayed. (1005)*

Honest and transparent discussion about relationships and people who would be supporting the woman in pregnancy, labour and birth and the postnatal period were integral to the trust expressed in the relationship between the woman and the midwives. Midwives reported that they had terminated arrangements in cases where a relationship had not been honest or they were unable to develop trust in the woman and on occasion, the woman's partner or family. One midwife articulated that she and the woman '*want the same thing*'; a safe, normal birth. Whilst this centred on feminist ideals of control and empowerment, these midwives talked about situations where safety of the woman or baby had to be emphasised when the midwife felt transfer was necessary for both clinical and intuitive reasons, occasionally at the expense of trusting the woman's own intuition about her body and her birth. Having a common goal that is served by a private midwife, achievable away from perceived institutional restrictions, aligns the midwife and her client reinforcing the trust in that relationship. The importance of reciprocal trust is demonstrated in the following narrative:

> *Because the relationship's so important. It's so much about the relationship with the woman for me. And, really knowing her and really knowing that she trusts me. But I also trust her... Because we're both in a situation where, we don't have that red button on the wall that we can press in an emergency situation, you know. Both of us are there and both of us believe that we don't need that button. Midwifery is based on relationships between women. That's the basis of it. It's a partnership. There's no hierarchy involved in it. We both want the same thing. (1003)*

One midwife criticised the hospital system for 'overloading' midwives physically and emotionally by the large numbers of women in a midwife's care in one shift. She described

this as a disincentive to forming, and being able to form, authentic, trusting relationships with women in her care:

> *We get into midwifery and we try to conform. We have to. You know the level of work and the peer review processes and reports and documentation and the rest of it. Staffing and writing in notes every 15 minutes keeps you from engaging with the woman. And there are requirements around accountability. (1008)*

She could not work without the benefits of relationship for its intuitive and therefore therapeutic benefit. This midwife had learnt to trust intuition that arose out of relationship. She stated:

> *It's not just about intuitiveness. It's like there's a connection that gets deeper and that fires off your intuition. Because that allows us that ability to really connect at a different level. And that intuition just slots in. It's not just about being a midwife. (1008)*

Another midwife who works privately and also at a large, public teaching hospital as a midwife, felt that the 'clutter' in hospital interfered with her intuition. She believed the environment is critical for the expression of intuition. This midwife expressed the idea that the environment of birth was influential. She found that women in hospital adopted behaviours and emotions that 'hid' the woman's real expression of her experience of birth and therefore interfered with the midwife's ability to trust the woman. She described it this way:

> *I just rely on my intuition at home. It tends to get a bit muddied in hospital. There's too much clutter, equipment, noise, staff changes, breaks. I notice that if I have a second midwife at a birth, I don't get a gut feeling or any intuition about things and in the hospital it's almost zero. But at a homebirth my intuition isn't muddied. So it's easy to tune in. I learnt that through experience... I can trust women in their own place... space. They don't hide anything at home. (0011)*

The discussion about the midwives' experiences of trusting women led to a discussion about their trust in themselves, their clinical judgements and their intuition.

### *'I've learned to… trust myself': Trust and Self*

Most of the midwives reported that learning to trust their intuition occurred in parallel with learning to trust themselves as women. One midwife explained this by saying:

> *Experience is just a wonderful thing. I feel far more comfortable now than I did. As a woman. But now having seen hundreds and hundreds of women have their babies... I think I react far differently now. I trust myself. I believe in myself that when I'm watching a woman in labour and my brains going and I start to listen to that other little voice. I actually trust that more. I've learned to trust it. (1002)*

Another midwife discussed the psychology of self trust. She spoke about the affect of her emotional life on herself and her consequent ability to be able to understand what women in her care needed:

> *I've always had this strong intuition. But there's been so much, in my personal life that, has kind of dragged me down where I've doubted it [intuition]. 'Cause I've doubted myself. When I doubt myself I can't rely on my intuition I can't trust where it's coming from. (1005)*

Another midwife felt that the reverse situation had occurred for her. She made a connection between learning to trust the women in her care and learning to trust herself:

> *You have to have a sense of who she is and what she's about, what her history is ...her medical history, yes but also her personal history. Her stuff. Her baggage. You know all the stuff she's carrying around that will make her birth harder or easier. We work it out over seven months. If I get a feeling about something at the birth I trust it now. I know I can because we've done all the hard yards ... together. I trust what I know. So I trust what I feel. Now. (1002)*

One midwife described her belief that fear interfered with her ability to trust her intuition. This belief resonated with all the midwives. One midwife described fear as *'the devil within'*. She had developed insight into the negative affect of fear and the cognitive affect of adrenaline and had developed techniques to assist her. She describes it here:

> *I felt uneasy for a while. I couldn't be intuitive and afraid at the same time. Fear blocks it [intuition] it's the devil within. I think when you're fearful you're in a different mindset. You've got the fight and flight thing going on and your adrenaline is going up and it blocks your intuition. You know if you're fearful, what are you*

*fearful of? And where's it coming from? If it's just history or something, you know ... but if it's your intuition. Then acknowledging it will eliminate the fear. It will play havoc. Settle, and then you feel the intuition again. (10010)*

One aspect of the concept of trust and learning to trust themselves was trusting their own experience of intuition. Several of the midwives had experienced voices, dreams and illusions with their intuition. Some were ambivalent about talking about this facet of their intuition and others were confident. One midwife narrated a story that she had discussed with very few people for fear of 'sounding crazy'. She was travelling to the birth of a woman having her second baby. The pregnancy had been easy and the woman and baby had been well. This is her story:

*And, I just had this sense I really had to get there in a hurry. Anyway, I had to stop for "Stop" sign, at a crossing. Anyway, I turned and looked right, to my right, and turned to look left, to my left and ... and there was a woman sitting next to me in the passenger seat – and she had an old English kind of accent, and I had a sense that she was not of this time, but older you know, mature woman but from a previous time– 18th century. She just said, "Don't worry. She'll be right." (pause) In a, "Don't, don't worry love. She'll be right" (said with a thick Scottish/Irish accent) Like that. (1002)*

The midwife arrived at the house to discover all was well but the baby was in a breech position.

*And because of that woman in the car, I thought, "OK. This is going to be alright". I still did call the ambulance and set up the emergency equipment and all that. But what amazed me, was, I hadn't done a breech in 10 years and all the knowledge that I'd learnt, suddenly, filed back into my head. And the baby was born, easily, and screamed right away. The ambulance came and went while we were waiting for the placenta but there were no problems. But I'll never forget that very strange woman that visited me. I was anxious to get there because she was moving fast and it was her second baby. I had a difficult birth two nights before and it was during school zones so I was driving really fast, driving really slow through all the zones to get there and I was a good hour away. (1002)*

Even though this was a unique and unexplained experience for the midwife she felt more invested in 'listening' to her intuition and trusting it as a result. The midwives' dialogue

around relationship and trust was illustrated with birth stories. Some stories were narrated over several pages of transcription. The stories were vibrant and some were sad but all of them revolved around the central theme that a midwife can work at her most intuitively when she has built a relationship with the woman in her care. A major aspect of that relationship is a shared trust. An integral component of that trust is that the midwife has sufficient knowledge that is both professional but also and importantly, personal, so that she can function autonomously, without fear. They all described using different kinds of knowledge, which included knowledge about the woman gained through a relationship based on trust.

## KNOWLEDGE

### *'... seeing and feeling with my eyes': Knowing*

The midwives considered knowledge and skill to be obligatory to practise private midwifery. However they all challenged established forms of authoritative knowledge around normal birth, valuing broader systems of 'knowing' and more intuitive knowledge. Although they reported a use of broader, sophisticated, embodied ways of 'knowing' that included intuition and challenged medical authoritative knowledge about birth, they acknowledged the importance of their primary clinical knowledge as a starting point for their midwifery education. The midwives expressed a strong commitment to knowledge gained from their clients and from lived, personal and professional experiences. They challenged the idea that obstetricians and hospitals were the 'indisputable experts' on birth, preferring to attribute real expertise about normal birth to midwives working within a normal birth paradigm rather than a biomedical one. A midwife explains the difference here:

> *Well, here's the thing. I work with well women, having well babies. They feel well. They feel empowered, not frightened by birth. Hospitals and obstetricians take their power away by frightening them with risk talk and poor explanations and no real eye contact and poor listening skills, and lots of ego. I look at them, listen to them, I want to hear them. Hospitals love drama and chaos. I don't need to frighten them to get them to do what I want. We work together. Hah! Together. Try and find that model in a hospital. (1009)*

All midwives distinguished between midwifery knowledge and midwifery skill. They expressed that midwifery knowledge was prescribed by the two dominant institutions; the

universities and the hospitals and was consistent whereas midwifery skill was more experiential, individual and variable. They all reported experiences within hospitals where they had practised using their knowledge without using their midwifery skill. One midwife describes her 'awakening' to the experience of midwifery compared to her experience of working as a hospital midwife:

> *I loved knowing how to work the machines and respond in emergencies. I loved the intensity. The adrenaline. The specialty of the environment and all the knowledge. What I found challenging was the women. Then I had my own baby. I got it then. I got the difference between a midwife who will work with you and a midwife who responded to the machines and drama. I changed overnight. In one birth. In one birth that was my own. I gave birth to my son and myself that night. (10011)*

The midwives felt they could practise in an institution without midwifery skill and intuition but would be required to have a sophisticated knowledge about machines, policies and procedures and a current obstetrical knowledge about birth. The difference appeared to lie in the environment in which the midwife practised and their definition of midwifery skill or knowledge. They did not believe they needed to understand normal, physiological birth to practise within a hospital. They all reported that they would not be able to survive outside the institution without a high degree of midwifery skills including intuition, illustrated in this quote:

> *I just chose not to work with drugs, machines, paperwork, bright lights, time constraints, rules, fear. I just wanted something more organic. More maternal. I had to learn SO many more skills. (1008)*

These skills are described by the midwives as part of a private midwife's knowledge and were considered essential to working safely without the 'rules, regulations and control' of birth in hospitals. The hospitals were considered by all the midwives to have pathologised pregnancy and childbirth and were directly responsible for controlling and diminishing 'real' midwifery knowledge and normal birth, for example:

> *My intuition is my own – it can't be given to me or taken away – it's for my use. I have the control. It comes from my life. It's part of my real midwifery knowledge. I've earned it and learnt it! (1003)*

Several of the midwives stated that their midwifery skills developed after they left the hospital environment. They developed these skills because they were necessary in the

context of private midwifery and had not been essential when working in hospitals. The data indicated that they were all using intuition and had a strong desire to retain it as a skill, develop it and increase their use of it in their practise of private midwifery. One midwife referred to herself as a 'hospital refugee' saying:

> *Working in the hospital didn't erode my desire to practise midwifery. It made me more determined. To get out of there and practice authentic midwifery. From my experiences in the hospital system, as a student, I never thought, ' Oh my God. I'm not going to go into private practice'. It was quite the opposite. It confirmed --- It was like, 'Oh my God. I'm never going to come and work in hospital.'(1006)*

Another midwife described her decision to practise privately as the result of hierarchical power and a feeling of powerlessness in practise. She was in charge of a busy, major teaching hospital antenatal ward on a weekend when staff was at a minimum. One of the women in her care had had several admissions during her pregnancy for recurrent vaginal bleeding. She was being discharged for the weekend and prior to leaving was having the baby monitored by CTG (cardiotocograph: continuous heart and uterus monitor):

> *The CTG just had a small section I didn't like. But a registrar looked at it and said it was fine, she could go. I wasn't happy. I looked at it again. It was OK but not great and given her history I ... I asked another senior midwife to look at it. She said it was fine. But I wasn't happy. The woman wasn't well, you know? She wasn't unwell. But something, I couldn't say what it was. There was something. I went to the evening in- charge supervisor. They called in a consultant. They did an ultrasound. They sent her home. She came back 4 hours later with a dead baby. Something was wrong. I was picking up on it but she met criteria so ... I couldn't argue without technological proof to support what I could feel. They overrode me. I was burnt–out, frustrated and fed up and had enough. I thought, well if I can't practice the way I want to then I won't. I'm a hospital refugee, I started privately. Now, I am responsible for all my decisions and all my care. If the opportunities for using my intuition don't present, then I don't use it. But if I get an intuitive sense about something ... I recognise it and follow through on it. Always. (1001)*

The midwives described that they had merged their embodied midwifery knowledge and judgement based on intuition and observation into clinical practises. They have created a culture within their networks that values knowledge developed through intuition and

observation and synthesises all learning into their professional knowledge. One midwife described how networks with more experienced midwives had facilitated her knowledge base in this way:

> *Each month we get together and talk about our cases and we review them. Whether it's been a poor outcome or an unexpected outcome or a good outcome. We have a network. There's a lot of opportunity to debrief and to really learn from much more experienced midwives or midwives with different experiences. That is so important. The different knowledge. (1003)*

Some of the midwives said that they learnt their most valuable skills from the women themselves. One midwife spoke about the knowledge she had gained from the women during a long private midwifery career. Here she makes a distinction between knowledge and skills:

> *I've got knowledge. I don't know more than other midwives. We all have access to the same information but I do have more skills. Women skills. I don't mind saying it. You know, what I've learnt? Leave the assumptions at home. The women have taught me what I need to know. I get to know every woman for who she is. At the beginning I go 'Well, let's get to know each other, let's see what we've got, where we'll go with this'. No two women are the same. (10010)*

She spoke about being present in two forms at births, both contributing essential but different knowledge. One part of her was the midwife who sat with the clinical knowledge and the other part of her was the woman who brought the skill of years spent attending women during birth. She said:

> *If you treat one woman the same as the next, if you standardise your care, make assumptions, you're not practising midwifery. When I go to a birth, I take the midwife along, I need her to be there, but she just sits in the corner. She stays quiet. I follow the woman. I follow her with my eyes, my nose, my ears, we just feel our way. Sometimes the midwife has to get up and get involved but not often. Mostly she's my quiet partner and I am the woman they need there with them. It goes nicely when you follow the woman. (10010)*

One midwife felt that her clinical skills were insufficient for understanding and resolving all situations. She felt that more subtle, more sophisticated processes were sometimes at work in intuition that allowed her to 'see' a solution or 'know' how to work with a situation or

problem. The midwives considered all information; knowledge. Several midwives described a sense of certitude when using their intuition that often did not accompany a clinical decision. Another described a difference between her use of intuition in the hospital setting and her use of it in the private setting in this way;

> *I work in hospital and home. Intuition at home, I think there's more flexibility and more allowance to just allow the woman to do the birth in her space and her own time, a little bit more than you would in hospital. Me being able to just follow from her intuition and to link in with that. And to also just have that...because you're with her the whole time, her understanding of where she is and how she's going without actually doing anything but just really by watching... (1007)*

Intuition linked to the senses was a strong theme in the interviews. One participant spoke about the importance of her sensory knowledge including sight and smell and her intuition in this way:

> *I'm using my intuition when I'm watching. And feeling. And sensing what's happening. I usually sit behind the woman where she can't see me. But she knows I'm there... just being present... Or I would just have my eyes closed or I'd be just sensing what was happening in the room without actually doing anything. (1008)*

The same midwife described that the less she did at a birth, the more she was actually doing, sometimes unconsciously, using broader systems of 'knowing' and midwifery knowledge:

> *So I do less and less and less the more births I go to. Sometimes it's my sense of smell. If I can smell adrenaline ... I don't know what it smells like. I just know when it's in the room. And because – particularly in hospital births women will tell you, "I could smell everybody's fear". And, I could smell it too. I don't know what it smells like though. (1008)*

One participant described an equal reliance on clinical knowledge and intuition:

> *How to very easily build a relationship with someone. And, using intuition. By having a sense of what's happening without actually physically having to do anything. Or having a sense of what might happen or is going to happen. But I don't rely on it [intuition]. I don't allow it to guide my practice. But it's definitely there and it is part*

*of, the way that I work. It's not a conscious thing though...If I really think about it; it's just part of, your midwifery kit. It goes hand in hand with my intuition. (1003)*

The midwives believed that intuition is a form of knowledge that builds upon clinical knowledge and affects and improves midwifery practice. They expressed a reliance on intuition for enhancing their skills at births and improving their clinical practises.

### *'... learning normal; institutionalised normal': Formal Skills*

All midwives in the study had gained their primary knowledge about midwifery through formal education and training at established institutions and their secondary knowledge through experience with their clients, other midwives and by learning from their experiences. The experiences they narrated were of both personal and professional in nature. The midwives all related stories about childbirth that revolved around a strong desire to engage in women's shared experiences; about women, their bodies and their legitimate, female 'knowledge' about birth . One participant speaks about a necessity to develop learning resources that complement more formal education styles:

*I think you start with formal learning and you move into your own experiences and I think it's the experience you get, wherever your work is, that guides you as to how much more formal learning that you participate in and what sort of learning that is. If you're university trained, that's formal. If you move into a hospital setting, that is still formal and that can perpetuate lots of formal learning. Courses and seminars and conferences. (1003)*

She emphasised the need to adapt learning to the work environment:

*But if you move into, like I did, much later in my experience, into private practice, I think your learning becomes different. You're not just receiving information. I learn through group learning now, and reflection and working with women in the community, from listening to women. And from like minded midwives. Where you seek your education changes. You go to the richest sources. Your learning changes as your experience does. I've learnt more in the last two years learning like that than I did in the 12 years before. (1003)*

One midwife spoke about the focus on technology during her formal education in this way:

*I honestly learnt to be preoccupied with the machines. Most of the focus was on how to set up CTG's (cardiotocograph monitors), IV's (intravenous catheters), IDC's (indwelling urinary catheters), epidurals (spinal anaesthetic), ventouse, forceps (instruments), theatre prep (preparation for operating theatre), pre-op, post-op, spinal blocks, pudendal blocks (anaesthesia), resuscitation for PPH's (post partum haemorrhage), blood sugars, diabetic crises, neonatal for flat morphine affected babies ... you know it goes on and on and we're causing it all. (1009)*

She saw this focus as being at the expense of learning the necessary skills and knowledge to enable her to work with women having 'normal' births:

*I had to learn how to make unsafe practice safe, and that was the complete focus. ... I needed to be able to monitor machines, I had to learn what was normal, institutionalised 'normal'. That's what I needed to know. How to be an obstetrical nurse. I couldn't have practised midwifery if I wanted to. I didn't see 'real' normal for a year. (1009)*

Another participant described her experience of a negative aspect of institutional culture that appears to insist that midwives are lower than medical staff on a vertical hierarchy and the women they care for are lowest. A vertical hierarchy often uses knowledge and institutional culture to enforce power and authority. The midwife expressed her concern about an institutional culture that exhibits a lack of respect for women:

*I witnessed a lack of respect for women in the hospital. Midwives and obstetricians. Everbody. It was a cultural thing and I saw a lot of bullying. Of women in labour. I often came home from there [the hospital] thinking 'I don't know how I'm going to continue ... to do this ... to get through'. And I had this, sort of, mantra that was 'co-operate and graduate'. (1003)*

The same midwife holds women themselves partly responsible for the demise of midwifery and normal birth saying:

*A lot of women in the hospital system just hand themselves over ... they don't want to take responsibility. They don't want to make decisions, they're too scared or they don't live that way, taking responsibility. Or they're completely traumatised by a previous birth. They are terrified and when women are scared the institution wields enormous power to control, power over decisions, pain relief, management. Too*

*much power and they love it. It all goes to hell. You can't live any of your ideals in the hospital. (1003)*

The midwives expressed strong views about the cultural impact of institutionalised learning and the negative consequences of conformity of knowledge. They all described enriched learning experiences outside the institutional setting where alternative and more encompassing ways of 'knowing' were acceptable. It may be a personality feature that this group felt 'outside' the dominant institution as students of midwifery and now practise midwifery as a marginalised group. Many of the midwives stated that they had to learn different and more subtle skills after leaving the institution. Some midwives spoke of the need to 'unlearn' to be able to practise effective, safe midwifery in a private context.

### *'I had to unlearn the institutional language and habits': Unlearning*

All the midwives felt that the environment at home and the hospital environment required different knowledge and skills. They described a need to 'un-learn' that labour was fraught with risk and inherently dangerous and 're-learn' to trust that pregnancy and labour could be processes that were more frequently 'normal' than 'abnormal'. This required un-learning and re-learning both professionally and personally. This meant that an institutional bias had to be reviewed in order for the midwife to practise without institutional fear attached to women and birthing. Again, a strong feature of the midwives description of their practice is that they are required to become emotionally involved in the birthing process to assist the women in their care and to benefit from intuitive insights. One midwife described having to 'unlearn' in order to practise privately:

*I have had to move away from formal learning. They taught me to make clinical assumptions. I've had to unlearn that. My skills and my intuition were undeveloped... I never really needed my intuition in the hospital ... I always worked to policies and protocols and so I had already predicted or, assumed what the end point would be. (1004)*

She compared institutional, authoritative knowledge that dictates what the parameters of normal progress of labour will be with midwifery authoritative knowledge that allows the progress of labour to unfold more subjectively. She describes it in this way :

*Whereas in private practice I have the choice to do things several different ways, so I actually experience it. And then see where she goes ... what the outcome is. And then make my own decision about what is effective, ineffective, what I might change with a different woman. (1004)*

Another midwife spoke about needing to learn two midwifery skill sets; one for hospital and one for home:

*I started with a formal education. I had lots of knowledge and I liked being in charge. I was subjected to a high volume of women and I chased experiences. It was very structured, very formal. I focussed on the system. It worked in the hospital. I was super confident. Then ... oh baby! I moved into private practice and I was shocked at how little I knew. What the hell! I needed a whole other set of skills. (10011)*

The same midwife described new skills she needed to learn which included relational skills that did not exert authority or power over women. The midwife had to divest herself of institutional behaviours in order to work with women outside the institution:

*I needed a new language, new skills, a new demeanour ... these women didn't want my important hospital knowledge. They could think for themselves, they wanted a real person, a midwife who could be present and listen and hear them and guide them and I needed to be able to sense what was happening and I needed my intuition on day one and I had spent 10 years not needing it, not listening to it and overriding it with 'science'. It was very uncomfortable. I started to learn that there's a lot I didn't know... I developed new skills and new parameters. (10011)*

Another described recognising that her midwifery care had become institutionalised and lacking in meaning associated with the relational aspects of midwifery care. She believed that 'busyness' prevented meaningful, individualised care. She expressed it in this way:

*In the hospital setting, people view you by how much you do. And how busy you are. You have to be directing and telling and organising all the time. You have to do all the work. Actually you're just mimicking a factory work ethic ... you know 'get em in and get em through and get em out' ... I had to stop doing that when I went to home. Because the less I did the more effective I was, the more I was doing meaningfully. (10012)*

Another midwife felt similarly about the difference between private practice and hospital midwifery practice where institutional rules are governing large numbers of people, patients and employees. She believed that efficiency belied safety and that individual women's needs may be overlooked resulting in poor or unsatisfactory outcomes for those women. She described it in this way:

> *I feel like before I just had to follow rules. The rules are for safety ... really? One rule can't possibly be the safest practice for, every, single, birthing, woman, on the face of the earth. Large hospitals can't cater for individuals. They are there for mass production – and a huge workload, for efficiency – staffing flow – so, the machine's efficient. It's about keeping the organisation safe – not the individual – with individual needs. (1007)*

One midwife commented that reflection had been an important component in her process of unlearning institutional behaviours and attitudes after she began practising privately. She stated:

> *Reflection. I learnt to really, honestly reflect in our small group of midwives. I had to learn to be brave to learn. I learnt how to learn in private practice. For a personal standard not the institutions standard of what they told me was important. I don't know how you could practice midwifery without honest reflection and help from people who really know. Unless you were happy to do the same thing every time, the same way, with every woman, just over and over, regardless of your outcomes. For me that's not what midwifery is. (1003)*

The following midwife spoke about the importance of learning about the woman herself. This theme was expressed by all the midwives and reflects their strong belief in the therapeutic benefit of relationship between midwives and women. The relational component of midwifery care underpinned every interview and was a substantial motivator in their decision to leave the hospital system and practice privately. The midwives were interested in the influence of a relationship built on trust during labour and birth and enjoyed using their obvious skills in this area when working with women. Regardless of the difficulties engaged during pregnancy, labour and birth the midwives reported better long term outcomes because they had developed those relationships. One midwife emphasised it in this way:

> *It's that other stuff ... the emotional stuff ... The woman. Who is this person, who's going to give birth? What does she do when she's frightened? What does she do when she's in pain? How does she react to strangers? There's this whole other bunch of information you need to get to know them, and their baby on an emotional level, because that's what labour is. Yes, there's a physical component but, women have got to get out of their heads to have their babies. (1002)*

The theme of knowledge, knowledge acquisition and knowledge formation was deeply embedded in the data. The midwives narrated many stories around their conscious and unconscious intuitive knowledge. They reported many birth stories that were detailed examples of their intuition in practise.

The next section is titled 'The Wise Crone Speaks' and explores the difference between the younger, less experienced midwives and the older, more experienced midwives approaches to discussing their intuition. This element arose during the interviews and is included for the depth of understanding it affords the reader. One aspect of private midwifery practise was the difference in confidence and conviction surrounding the more experienced, older midwives use of intuition.

### *'... the wise crone speaks': Knowledge that comes with experience and age*

The findings revealed an obvious divide between the less experienced and very experienced midwives' use of intuition and their trust in it as reliable, legitimate knowledge. Maturity as a woman and longevity of experience as a midwife appeared to separate the midwives. Age and experience defined the midwives and was integral to their way of functioning within a midwifery context but also in their relationships with clients and other midwives. The mature, experienced midwives were unapologetic about using and relying on intuition in their midwifery practice. Whilst the less experienced midwives all had a minimum of three years private practice experience, it was quickly apparent that the longer the midwife practised privately and autonomously, the less conflicted she was about using intuition and knowledge from non-authoritative sources. The more mature they were in age, the more relaxed about the confidence of practices developed from long years of experience. This was a significant feature and will be further explored in the context of feminist standpoint theory in Chapter 5.

Five of the twelve midwives were 50 years of age and older. These mature midwives expressed more confidence verbally in their intuition. Notes taken immediately following the interviews recorded that their body language was also more relaxed and at ease when describing their reliance on their intuition when practising their midwifery. The following excerpt illustrates this observation:

> *I keep doing this. Don't I? [From field notes: gently rubbing lower abdomen] I wonder what that is? I don't have a uterus anymore. That space ... Where my uterus used to be. Possibly I've always had this strong intuition. But there's been so much, in my personal life that, has tried to drag me down, where I've doubted it. 'Cause I've doubted myself. So, when you say something about the wise crone, I think, as a rite of passage, going through menopause has given me a sense of, not confidence so much. Well, I just know that, I can be with women, and I am able to provide, a place for them to give birth where they feel safe. But it feels, so, right to be doing it at this age. (1005)*

She emphasised that a lack of cognitive and emotional distraction became an asset to her midwifery:

> *We can teach younger midwives or women to be women who will have intuitive aspects to their practice the longer they practice and listen to it. To actually trust it. Is it linked to experience and ... Your feelings about yourself as a woman. I think, and maybe there is something, with the old pagan ways of looking at the wise crone, that she actually has to be anovulatory, for her brain to function – What I have noticed is my short term memory is not as good ...But, other aspects of my brain is much more astute. Much more developed. (1005)*

Another mature, very experienced participant expressed the same theme in her description of intuition and truth. She said:

> *Intuitiveness as women is something we can't get away from. And I think that is about being, true to ourselves. And true to the women that we actually work with because of the relationships that we form with them. I just don't see that we can form those same sorts of relationships, within the system on a normal basis. So that's why I say about, you know speaking our truth, and practising our truth as women first and midwife second. (1008)*

One, mature midwife described her ability to access intuition as the result of emotional maturity. She expressed it in this way:

> *I don't think you can teach intuition. I think you can give, people permission if that's what they require ... To listen to themselves. And, part of that will be an emotional maturity. Some people are never going to get there. 'Cause they're too disconnected from self. 'Cause I would actually argue that part of it is about your inner peace, as well. And, you know the more comfortable you are as a woman – intuition will be switched on much more. (10010)*

## Summary

The study had two major themes; Trust and Knowledge. All the participants were using intuition in their practice. The midwives all described a strong link between their intuition and their senses. Their intuitive use of sight, smell and sound were repeatedly mentioned. Whilst they experienced difficulty when asked to locate where their intuition was occurring and how it was occurring they were vivid in their descriptions of when they had used their intuition for; information; checking clinical signs against their 'gut' feelings; and when solving problems and originating ideas during labour and birth. Learning about midwifery after their formal education, was socially organised and their clinical skills alone were insufficient to deliver safe, meaningful care in a private midwifery context. They reported that their intuition increased with trust of self, trust of women, emotional maturity and a supportive environment and finally; none of the participants in this study would practice without intuition.

The midwives emphasis on the importance of trust between the midwife and the woman she was providing care for was fundamental to every interview. This feature was explored within the context of intuition but was so entwined in the discussion of private midwifery itself that it warrants further investigation. Procreation and childbirth are so historically bound to feminism and the birth culture of claiming back the female body that it was unclear as to whether the midwives were projecting or protecting when they narrated stories about birth and trauma, control and re-birth, knowledge and the legitimacy of other ways of 'knowing'. Regardless of their motivation the perceived connection between trust, relationship, knowledge and intuition was evident. In the next chapter a discussion of the findings is presented.

# Chapter 5

# DISCUSSION

## Introduction

This chapter discusses the study findings by providing an overview and examining the details of the midwives' description of intuition. The discussion explores the midwives' experiences in relation to what is known about intuition and what other researchers, in the existing body of literature, have found. The discussion uses current neuroscience theory about the biology of intuition to further explore the themes and provides some background to intelligent memory. The integration of the literature, this research and the practice of private midwifery has allowed a layered synthesis that connects the study participants, events surrounding their experiences, the process of their thoughts and knowledge and also the past and current issues surrounding childbirth in Australia. The chapter ends by identifying the limitations of the study and closes with a summary. Understanding and further exploring the meaning of intuition is the first part of this chapter and references the section in Chapter Four: Midwives and Intuition.

### *Overview of the findings*

All the midwives used intuition in their midwifery practice however none had thought about what intuition was and how they used it prior to being interviewed. None had any formal understanding or reference for understanding the cognition of intuition however all provided detailed descriptions of situations where they had been conscious of using their intuition to make judgements and find solutions, whilst working with women during pregnancy and childbirth. Their narratives revealed midwifery practises that were infused with both subtle and complex intuition. The midwives' stories about birth described how their intuition significantly enhanced and dignified their contact with childbearing women. All stated that they could not practise midwifery without intuition.

Two major themes emerged from the analysis: trust and knowledge. These themes explored the midwives' understanding of intuition and the influence of trust and knowledge on intuition in their own words. They explored their 'lived experience' of intuition in their practice and their descriptions produced the themes. The first theme was trust. Trust was

explored through the three aspects of practice where the midwives used their intuition, these were; relationship, women and self. The second theme was knowledge. Knowledge was explored by examining the midwives understanding of knowledge and intuition, their ideas about formal knowledge acquisition and intuition and knowledge or institutional bias that had to be un-learnt in order to practise effectively in private midwifery which I have called, unlearning.

### *Motis cordis: The moving of the heart*

One midwife described her intuition as '... the consciousness of my skin'. This lovely description reflects the intimacy and care that infused all the midwives narratives. They all engaged their minds and their hearts when working with women during childbirth. The depth of their caring for their clients was manifest in the degree of sensory language used to describe their understanding about the physical and emotional demands of pregnancy, labour, and birth. This description summarises the matrix of sensory and cognitive information that the midwives listed when speaking about intuition and is the foundation of the descriptors involved in the identification of 'intelligent memory', which until Kandel's (2012) work in neuroscience was called intuition. The following quote is from Berg and Dahlberg's (2001) Swedish study and reinforces the universally identified sensory nature of a midwife's experience of intuition and gives us insight into how midwives allow their hearts to be moved whilst working with women:

> *I have to hear what she is saying. I have to hear, I have to feel, absorb what it is she wants, what she's afraid of, what she is going through... I can feel it in the air, feel it in the vibrations, I can see it in her body language, hear how she breathes, speaks.* (Berg & Dahlberg 2001, p. 263)

Intuition is a widely used concept in midwifery, nursing and health care generally and a range of literature articulates key components of intuition (Bastick 2003; Duggan 2007; Eraut 2000; Kandel 2001; Klein 2003; Olafsdottir 2011; Rew 2001; and Wickham 2004). This evidence-base highlights the links between intuition, expertise (Benner 1984) and the historical acceptance that women and midwives use intuition as a fundamental part of their knowledge (Cassidy 2006; Davis-Floyd 1997; Ehrenreich 2005; Evenson 1982).

Research into intuition and midwifery practice (Berg & Dahlberg 2001; Downe, Simpson & Trafford 2006; Olafsdottir 2011; Winter 2002) has attempted to clarify midwives'

understanding of intuition and determine the culture and context of its use. Whilst this is reflective of the findings of other studies examined in the literature review, none of the studies attempted to define intuition and no studies investigating midwives use of intuition were found within an Australian context. Furthermore, the studies referred to in the literature review do not explore the current thinking, research and developments about intuition that are emerging from the field of neuroscience. My research findings confirm descriptions of intelligent memory in current neuroscience and suggest that midwives intuition is an integral and unconscious source of 'information' that significantly contributes to their practise of midwifery.

Many studies suggest that intuition enhances a midwife's expertise and 'emotion work' (Hunter 2001) when working with women during pregnancy, labour and birth. My study found, as did all the studies in the literature, that the midwives placed substantial value on emotion work and the relationship between themselves and the women in their care. Whilst Hunter (2001) established that emotion work was fundamental to relationship building, Hubble et al (1999) identified relationships as the core component in a 'therapeutic alliance'. Hubble et al argue that the relationship will only have meaning and therapeutic value if the core conditions of acceptance, empathy and genuineness exist. The midwives in my study related their ability to engage in the emotion work and relationship building as an essential component of that relationship affording a therapeutic value for the women in their care, regardless of the birth outcome. Another study by Bachelor (1995) revealed that it is the individual client accessing health care that decides whether a relationship has therapeutic value and is beneficial to them rather than the carer or health service provider determining what is beneficial or of clinical value to the client. This is important in terms of responding to, and learning about, the benefit of midwife-woman relationships and determining the models of care that offer greater therapeutic benefits. A model of care that offers continuity has been found to be preferred by women and midwives (Sandall et al 2013). The midwives in my study reported that their intuition occurred more frequently when they had developed a relationship with women in their care, further supporting the literature.

My study explores the midwives' descriptions of their intuition and interprets their dialogue using current neuroscience theory. Neuroscience is the study of the nervous system and the brain. It examines the development, structure and the cellular, functional, evolutionary, computational, molecular, cellular and medical aspects of the nervous system and the

brain. Neuroscientists focus on the brain and its impact on behaviour and cognitive functions. Kandel's (2012) work establishes a neuroscientific, cognitive framework for intuition that extends on Bastick's (2003) seminal sociological work into intuition. Kandel has called his work 'Intelligent Memory' in order to distinguish between the sciences and to establish a neuroscience perspective. For the purpose of this study I will refer to the phenomenon as intuition when relating it to Bastick's work and intelligent memory when identifying a relationship with Kandel's research. The next section describes the development of the science of intuition and provides a definition of intelligent memory.

### *Intelligent Memory*

In the introduction to the study, the history of intuition was historically referenced. It has been described in philosophy, religion, sociology, psychology, neuropsychology and most recently, neuroscience. Current research and both midwifery and feminist literature advocates women and midwives ownership of intuition as authoritative knowledge and argues its legitimacy from sociological and political perspectives (Downe et al 2004; Fahy 2007; Fry 2007; Kennedy 2001; Kitzinger 2005; Oakley 1980; Parratt 2008; Smith 2007; Wickham 2004). However, it is within the discipline of neuroscience that a biological framework for understanding the cognition governing intuition is found (Duggan 2007; Gordon 2003; Kandel 2001; Klein 2003). As a result, it is now possible to attempt to establish it as a legitimate source of knowledge used by midwives, not as a form of alchemy but as epistemology, a form of knowledge in regard to its methods, validity and scope and distinct from justified belief or opinion.

Kandel's work shows that the brain is a highly differentiated organ in which consciousness resides but does not necessarily drive thought (Kandel 2001). It contains approximately one hundred billion neurons that form networks of connections and communication. One hundred billion neurons are about the same number of known stars in the galaxy. The potential communication between these neurons is limitless and it is suggested that 95% of our perceptions or awareness is unconscious (Klein, 2003). That means that only five percent of our thinking and awareness of information, both internal and external is conscious. In any situation, an individual's state of consciousness is the primary factor, alert attention or 'presence of mind' awakens neural networking and as a result innovation of thought is possible as the subconscious draws on information from a matrix of brain processes including memory (both working and long term), specific, contextual information

and the senses (Duggan 2007; Kandel 2012; Klein 2003). Consequently, intuitive processing could be likened to a non-conscious scanning of internal (in memory) and external (in environment) resources in a non-logical, non-cognitive manner in order to identify relevant pieces of information that are fitted into the 'solution picture' in a seemingly haphazard way, similar to assembling a jigsaw puzzle. When the assembled pieces start making sense, the 'big picture' suddenly appears, frequently accompanied by a feeling of certainty or relief. The non-conscious aspect is reflected in being unaware of any reasoning going on in our mind prior to the 'appearance' of the solution (Duggan 2007; Kandel 2012; Klein 2003).

Kandel's (2012) work, which led to a Nobel Prize, established the physiology of intuition in the brain and for scientific legitimacy renamed intuition as 'intelligent memory'. Intuition has been considered a popular rather than scientific term since the early 1970s (Bastick 2003). A feminist perspective might suggest that 'renaming' intuition which is a historically female gender associated phenomenon into a male 'scientific' label is perhaps an indication of the paternalistic attitudes that have suppressed the consideration and use of intuitive, embodied knowledge as a legitimate source of knowledge. Nevertheless, intuition has been scientifically observed, quantified and described and is now referred to as intelligent memory (Kandel 2012). Kandel's work on intelligent memory involved extensive neurobiological testing and is an extension of the known brain science underpinning both short and long term memory. Bastick (2003) previously identified the sociological-emotive responses involved in intuition using a psychological framework.

Neuroscience argues that whilst elements of knowledge are rational and may involve scientific enquiry, other elements are sensory based (Duggan 2007). All information, including academic and sensory, arrives to the conscious brain as an idea which is a completed form of information synthesis (Kandel, Schwartz & Jessel 2001). This synthesis of information is intuition (intelligent memory). The next section examines the details of the midwives descriptions, understanding and use of intuition.

### *The Study: Conscious and unconscious knowledge*

All of the participants in my study described their intuition as sensory based and several of them also believed that there was a cognitive element involved. The midwives could not separate intuition and conscious thought. Bastick (2003) identified that the structure of

abstract domains such as intuition appears to depend, in part, on both linguistic experience for perception and on physical experience for motor action.

Pinker's (1997) work on language and metaphor shows that we can only describe that which we have language to attach to a description. Studies demonstrate that the metaphorical language people use to describe abstract phenomena, such as intuition, provides a window on their underlying, cognitive representations (Pinker 1997). Interestingly, as my study has shown, with regard to intuition, people who talk differently do not appear to think differently. The studies identified in the literature review illustrate how midwives in the northern hemisphere with different languages, experience intuition similarly, almost identically, to the midwives in my study. This reflects Bastick's premise and suggests that midwives are likely to track the kinds of correlations in experience that are important for perceiving and acting in their environment, whether consciously, or unconsciously. Bastick (2003) showed that the intuitive process is analytical but independent of the thinker and proceeds from the conscious and the unconscious brain. The following quote from Winter's study is descriptive of Bastick's findings:

> *I don't know, I don't know. It's what we discussed, we don't know whether it's because you have experience somewhere along the line that given a particular circumstance that you recall that from your subconscious or whether it's, I don't know, I can't separate the two. (Winter 2002, p. 91)*

Kandel's (2012) work on intelligent memory describes the subconscious as a storage place for experience that cannot be erased and may be unconsciously accessed when caring for women. Thoughts and ideas may become stimulated by the unconscious memory of the environment, temperature, sounds, smells and other sensory information that has been stored during a working life, as well as learnt information and facts that are recalled to the conscious brain when required. A process that may be achieved by thinking or unbidden, by memory stimulation (Kandel 2012), this process is described in the literature as 'matrixing'; a complex synthesis of information stored and filed throughout an individual's life and accessible both consciously and unconsciously (Gordon 2003). Some of the midwives did not believe intuition was a facet of the midwives learned knowledge, but that it was an unasked for *'presence'* that informed their work with women. Others believed it was part of learning and knowledge accumulation.

The process of intelligent memory (Kandel 2012) combined with focused attention culminates in intuition (Bastick 2003). The 'matrixing' ability of the brain seems to have been identified by several midwives who *'sensed'* that a culmination of sensory information provoked intuition. As well as an awareness of the sensory information, one midwife referred to memory when describing her understanding of what provoked her intuition. She believed that memories of odours and visual memories that formed '*pictures*' allowed her brain to '*connect the dots*' and cause intuition.

Midwives in my study spoke about their understanding of both visceral and cognitive elements of intuition. They reflected as they spoke and they processed their thoughts as they narrated stories about births that illustrated their ideas about intuition. Their understanding of intuition was experiential and related to the 'emotion work' of working with women in their care and their acceptance that intuition would emerge when needed. Their intuition would manifest as an idea, sudden insight, creative solution or sense of 'knowing' something that would influence their care for a woman. They described their intuition as discerning subtle physical cues, not obvious clinical assessments that are reliant on machinery or, on obvious, anticipatable facts. Kirkham refers to this as a trend toward '*High tech but low care solutions'* (2009, p.237). One midwife said that she could better assist women during labour and birth if she had a '*sense*' of the woman herself rather than the woman's clinical measure. She expressed it in this way:

> *I don't agree with using drugs, needles and all the technologies that depersonalise birth and control women. They're poor substitutes for the real exchange of breath between us, sweat, touch, pain and the joy of that sweet, new flesh pressing into hers at the end of it. (1005)*

The midwives in my study described a territory of subtle, individual terrain that they navigated by feeling their way, using the investigative skills that are reliant on being present and responsive to individual women. The discussion now proceeds by exploring the two themes that emerged from the analysis.

## Exploring the Findings

### *Trust*

The first theme that came to light in the analysis was trust. The midwives spoke about trust with respect to three areas; trust as a by-product of the relationship they developed with the women, trusting the women and trusting themselves and their own intuition. I will begin by interpreting the midwives' concepts about relationships.

### *The Importance of the Relationship: Consciousness harnessed to flesh*

The bond of relationship that forms between the midwife and the woman has been shown to increase trust and assist women emotionally during pregnancy, labour and birth (Homer 2001). The development of trust in this significant relationship emerged as a strong theme in the study findings. All the studies reviewed in the literature report that the relationship between the midwife and the woman in her care is fundamental to the existence of intuition. Winter's (2002) midwives described their relationship with the women as the *'foundation'* of their knowledge when working with their clients. The midwives in my study believed that developing a relationship with a woman antenatally raised their consciousness of her unique needs and increased their intuition during the birth.

The interdependent nature of trust and relationship is well understood in the midwife and woman relationship (Homer 2009; Kirkham 2000; Leap 2000). The participating midwives connected their intuition to the development of trust in their relationship with women in their care. Private midwives practise within a continuity of care model where care and support are not interrupted or shared between multiple providers. The midwives believed that building a relationship with the woman (and families) in their care was integral to experiencing intuition when assisting them during birth.

Olafsdottir (2011) also found that the midwife-woman relationship was integral to intuition. Her study reported a lack of intuition when they did not '*feel connected*' to their clients or had not had the opportunity to develop relationships during the pregnancy (Olafsdottir 2011). The midwives in both Olafsdottir's and Blaaka and Schauer's (2008) studies described empathy and emotional involvement as part of the sensual skills used to work with women. Bastick (2003) found that relationship and empathy directly influence the expression of intuition and that emotional involvement is central to all aspects of it. He describes the link between emotion and intuition as the participation of 'concrete' and 'abstract' perception

about past and present experiences that result in intuition on the part of the observer. He further states that emotional involvement is most obvious when intuitive processes result in invention and discovery. Bastick's statements resonate with Blaaka and Schauer (2008), Olafsdottir (2011) findings. My study also found that the midwives relied on intuition for moments of insight and unexpected knowledge that resulted in effective solutions for women in labour.

Bastick's (2003) work showed that intuition was dependent on emotional involvement and that logic was unattached to emotion. Bastick showed that intuition relies on past experiences and the present situation of the 'intuiter'. He demonstrated that logic and analytic thought is 'cold' and emotion free, non-relational, and independent of personal experience, property and the immediate environment. Logic and analysis are increasingly features of midwifery practice as birth becomes technologically focused and reliant on machinery, thereby involving fewer human centred skills that rely on empathy (Odent 2013). According to Hunter (2001) the major component of emotional involvement is empathy.

Kirkham (2000) refers to empathy when describing the value of the midwife-mother relationship. She argues that subjectivity requires empathy that is perceived as 'caring' and feminine. Kirkham (2000) states that care, empathy and relationship will never be as professionally valuable as the 'clinical assessment', 'monitoring', 'testing' and 'clinical advice' associated with institutional medicine and treatment. As explained earlier, this is reflected in the vertical hierarchy of established medical institutions where the power to influence models of care continues to be largely male and located at the top of the hierarchy (Lane 2006). This hierarchy of control is associated with 'expert' clinical knowledge and prestige and lower down the hierarchy more females and feminine traits are expressed through less powerful caring and nurturing roles involving emotional investment that support the services above them (Lane 2006).

Intuition has, historically been associated with women and as Kirkham (2000) and Lane (2006) argue, its clinical value is subsequently afforded a lower status. The midwives reported that the vertical hierarchy was influential in their decision to leave the hospital system and several spoke about their desire to work with women who required their unique, expert skills to avoid drugs and a medicalised labour and birth. Downe, Simpson and Trafford's (2006) systematic review and meta-synthesis of papers and journals between 1970 and 2006, explored intrapartum midwifery skills and identified three concepts that

always occurred together when expert, exemplary practice was identified; wisdom, skilled practice (which included using intuition) and enacted vocation which expressed prioritising the values of courage, empathy, trust, relationship and intuition.

The midwives in my study used their relational skills involving empathy and their preparedness to do 'emotion work' (Hunter 2001) with their clients. This contributed to the expression of intuition and in fact cannot exist independently as Bastick's (1983) research showed.

The feminist construct toward an attitude which values empathy and emotion work is often what draws women to find a midwife who will 'invest' in her emotionally and physically and this is often a midwife in private practice. The desire for a relationship between a woman and her care provider is well documented in the literature (Downe & McCourt 2004; Fahy 2005; Hatem et al. 2009; Homer, Brodie & Leap 2008; Homer 2009; Kennedy 2000; McLachlan et al. 2012; Siddiqui 1999; Winter 2002) The absence of relationship and standardised institutional care that focuses on productivity and risk management diminishes the value of emotion work for large numbers of women and has been shown to be counterproductive to promoting or enabling normal birth (Benoit et al. 2005; Blaaka 2008; Downe 2006).

The affect of limited or no continuity of maternity care on birth outcomes has implications for midwives working in the institutional setting who have limited or no contact with women antenataly as is the case in much of Australian maternity care. The midwives in my study believed that birth outcomes were improved when a relationship had been established during the woman's pregnancy. A conclusion can be drawn from Bastick's (1983) work that where there is no opportunity to build a relationship with a woman during her pregnancy, the midwife will be unable to access intuition. That is not to say that good or excellent midwifery care cannot be achieved within institutions but rather if intuition is valuable for the provision of individualised, expert midwifery care, it will be absent where the emotion work that comes from relationships with women is not achievable. This is important for midwives who have increased access to intuition because of their work situation and who do not want to relinquish it as a resource. Consequently, maintaining an environment that stimulates intuition reduces the number of environments those midwives can work in.

As pregnancy and birth become increasingly medicalised and the focus of care is technologically driven, midwifery and midwives who need to build relationships in order to utilise all their skills, could become underrepresented in the workforce. This, in turn, will reduce the knowledge and diversity of midwifery skills available to newer, less experienced midwives. Not only will a reduction in the number of midwives with relational skills ultimately diminish the scope of midwifery practice but, logically, it will create a less diverse and more specific orientation of midwifery knowledge and skill as institutions demand less 'midwifery' and more 'obstetrical' or 'mechanical' and 'technologically' oriented midwives. As previously stated, all the midwives in my study would not practice without using intuition. Similarly, the studies by Berg and Dahlberg (2001), Hunter (2007), Kennedy (2002) and Winter (2002) all found that midwives associated intuition with expertise and could not work without it. The midwives also reported that environment influenced the occurrence of intuitiion.

Bastick (2003) has identified how the environment is important to intuition. Bastick collated 20 properties commonly attributed to intuition that attempted to eliminate descriptive ambivalence. He found that *'intuition is a product of thought and behaviour that occur under particular conditions of personality, environment and experience'* (p. xxxv). These conditions are not mystical but commonplace and familiar. The private midwives in my study practice in a context that contributes to their intuition and exemplifies the conditions described by Bastick (2003); non-threatening, empathetic, unconventional, collegiate, reflective and relationally focussed. He found that the opposite environment diminishes both intuition and learning. Bastick (2003) found that the components of that environment were; rote learning, analytic tasks, dependence, authoritarianism and displays of power and aggression. These characterise some aspects of hierarchical, institutional behaviour that provoked one midwife to refer to herself as a 'hospital refugee'.

The midwives in my study frequently related stories about past experiences and thoughts that not only influenced their emotions but also evoked a response. The parallel here is that this cognitive process is described by Bastick (2003), as a primary and a secondary process. That is, the memory of an experience can evoke a response as strongly as the initial event and reflection can stimulate an intuitive response the next time those emotions are felt. The significance of this information is that midwives are unconsciously 'learning', recording and creating cognitive resources for solutions at every birth, every time they are emotionally involved. The midwives reported that they are emotionally involved when they

have developed relationships with the women (and families) in their care. Trust exerts a significant influence of these processes and was the strongest theme to emerge from the data.

Bastick (2003) has established that trust and relationships precede intuition. These findings are supported by current neuroscience theory (Kandel 2012) which has extended on Bastick's work so that it is now known that the brain processes and records a range of information from a variety of both cognitive and sensory sources that can be accessed and retrieved as necessary or when stimulated by contexts such as environment, stress or attention (Duggan 2007). This information is made up of both conscious and unconscious material. The rapid, complex synthesis of what is consciously but also unconsciously known and the combination of those elements is now referred to as intelligent memory (Duggan 2007).

As the literature and the discussion have shown, intuition or intelligent memory are more likely to flourish in the environment that private midwives practice in. The participants in my study reported that intuition is a valuable and necessary aspect of midwifery practice that they perceive is essential for good birth outcomes. This poses the question; how do we create the conditions in institutions that encourage midwives to develop and use intuition? As Siddiqui commented in 1999; '*The relationship that develops between the woman and the midwife is at the core of human caring and may provide the basis of the professional body of knowledge that encapsulates midwifery'* (Siddiqui 1999, p. 111). The answer must lie partly in protecting the opportunity for women and midwives to develop relationship by the further development of midwifery-led models of care (Sandall et al 2013) but may also require that unique midwifery knowledge be protected and valued by the profession itself. Another aspect of trust involved in the midwives experiences of intuition were the women.

### *Women: The thinking heart*

Kirkham states *'Where people meet for the first time when a woman is in labour, much energy can be wasted in building up the trust that does not come easily on first acquaintance'* (2000, p. 14). This statement reinforces the association between trust and relationship but more significantly it represents the midwives' perspective. The midwives in my study spoke about their clients with a compassionate heart, a wonderfully watchful, eloquent heart. They emphasised the benefits of establishing a relationship throughout the

antenatal period because of the benefit to the women in their care. They also expressed the idea that reciprocal trust had a significant impact on the experience of the relationship between the midwife and the woman. Where there was reciprocal trust the midwives felt their intuition was increased. Where the midwife did not feel she could trust the woman (or sometimes other family members) or, the established trust was dislocated, the midwives experienced greater anxiety surrounding the birth and consequently relied on more clinical assessments and analytical thought. The midwives reported that these factors had the effect of reducing the incidence of their intuition.

Midwives spoke of assertiveness in terms of having '*it in my ovaries*' to be able to terminate an unsuitable arrangement with a woman. This was a significant feature of dialogue because several midwives used the phrase, 'got the ovaries' during the interviews. It was both amusing and interesting to note that an appropriation of a vernacular phrase suggestive of a feminist ideology is part of the private midwives colloquial language. The phrase communicated courage, which was a necessary component of the midwives emotion work with clients. It also implies that the midwife has developed and matured both personally, by appropriate boundary setting and professionally in terms of being able to cancel contracts with women (and families) who are inappropriate for her practice. Unlike a midwife operating within the hospital setting, the private midwife can exert some control over her environment by managing 'inappropriate' clients thereby reducing the associated stress and fear of anticipated negative outcomes and reducing extraneous risks.

Other studies have linked stress and intuition. Bastick (2003) identified that stress subjectively reduced the incidence of intuition and Kandel's (2001) work showed that the noradrenaline produced by the adrenal glands during stress or when anxiety is present actively interrupts the neurotransmission of cognitive synapses associated with the activity of intelligent memory (Kandel 2001). This means that during periods of stress or fear, the brain is inhibited from matrixing the necessary connections which allow intuition to occur (Duggan 2007). Whilst the midwives were unaware of the biology of the cognitive inhibition of their intuition, they were aware of the subjective effect of a lack of trust in the women or her attendants during a birth. The effect of a lack of trust resulted in a level of anxiety that further inhibited communication, the relationship generally and the midwife's experience of intuition. This 'experiential' learning was frequently reported by the midwives during interviews and suggests the important nature of one of the aspects of learning that contributes to knowledge and the midwives specific epistemology.

The midwives all placed importance on the emotion work that was involved in working with women. They believed that emotional involvement and the complexity of those women's lives contributed to the therapeutic alliance established during the pregnancy. The midwives all expressed a belief in the therapeutic benefit of a connection with the women in their care for both the women and themselves. They expressed a greater incidence of intuition where they had been able to form relationships with women based on trust. Even though proponents of experience-based intuition focus solely on the cognitive elements of the construct, my own findings indicate that intuition also includes an emotional or affective component. This view is consistent with conclusions drawn, among others, by Bastick (1982), Epstein (1998), and Petitmengin-Peugeot (1999). This suggests that emotion work and intuition are strongly linked.

Reciprocal trust was emphasised by the midwives and dominated several discussions about the nature of women during the interviews. No discussion surrounding midwives trusting the women in their care was found in the other studies and it appears to be a unique feature of this study. Related to the theme of trust and situated within the framework of feminist ideology, the midwives also spoke about the politics of operating within the world as women and as midwives.

### *Standing Up Against the Establishment: Now that takes ovaries*

The private midwives who participated in this study appear to have formed a midwifery feminist ideology that rearticulates conscious midwifery practices that are emphatically woman-centred and courageous. These practises aim to empower women and midwives and stimulate resistance to the dominant medical obstetrical model of care that has pathologised 'normal' pregnancy and birth (Lane 2006; Odent 2012). The midwives used midwifery-derived conceptions of self, women and 'trust' to resist negative evaluations of women, birth and midwifery that are advanced by dominant organisational groups. These midwives' grounding is firstly their experience of womanhood and femaleness and secondly a gendered, midwifery education that fosters the development of a professional code of practice that is independent, autonomous and 'with woman'. This process could be interpreted as a female, midwifery 'standpoint' (Smith 1987). The midwives unanimously rejected socially constructed controlling mechanisms of medicine and pre-eminent 'knowledge' systems. The dominant ideology of the current obstetrical view of pregnancy and birth reflects the dominant group's interest in maintaining midwives' subordination.

The very structure of hospitals delivers a hidden socioeconomic curriculum of standardised care, professional competition and top-down management by experts.

Several midwives referred to an example of this subordination by the medical fraternity and the Australian Medical Association's (AMA) recent attempts to control private midwives' access to indemnity insurance (Reed 2013). Within the AMA, it would appear that certain assumed qualities have been attached to private midwives who have been negatively represented in the media and this has contributed to the nexus of negative stereotypical representation that influences popular culture. These negative associations have been used to justify the professional oppression of private midwives (Lane 2006). Private midwives have tried to resist these derogatory stereotypes through the creation of a private midwives distinct standpoint that is based on women's own experience and meanings of birth. Blaaka and Schauer's (2008) study found that the practice of male derived 'science' within the biomedical institution has created a hostile environment for midwifery 'ways of knowing' because of its female origins.

Some of the midwives referred to prejudice within their profession from colleagues and midwives, which raises concerns about current midwifery education and training. The midwives in my study had elected to abandon the institution in an attempt to remain close to the ethics of 'being with' women and the practises of midwifery knowledge and skill. However they historically and currently remain a minority group. Some midwives discussed the cultural and political role of motherhood and the pressure exerted by feminism onto the meaning of birth and women's experience of it.

### *Motherhood and Motherwork*

Some feminists would argue that motherhood has been the locus of women's oppression (Wolf, 1993). The midwives interviewed for this study however argued that they reject the notion of maternal oppression in terms of both gender and profession. They argue that in practice and philosophy they work to preserve, protect and more generally, empower women and other midwives so that they can resist practices that could compromise their feelings about control and their freedom to make choices as well as a sense of power during childbirth. O'Reilly (2004) describes empowered mothering as using the role of mother to challenge systems that smother women's choice, autonomy and agency. During the

interviews the midwives voiced concerns centred upon the recognition that childbirth and the work of mothering has cultural and political importance.

They strongly expressed concern about the physical and psychological wellbeing of women and their children and the value and prominence that birth, as a consequence, is a site of power for women. The midwives also expressed deep distrust of institutional medicine and 'medicine men'. This was reflected in many stories of looking after women who had regretted their choices or felt remorseful following a bad birth experience and wanted a female midwife she could establish a relationship with and trust to help her birth again. Again, trust in women, the environment and the midwife herself emerged as integral to control and satisfaction or therapeutic benefit. The midwives all reported that they felt their trust of themselves was pivotal to their intuition.

### *Heroines and Misfits: It's all in the mind*

During the interviews, the midwives expressed the view that trust was an enabling emotion for women. What also became apparent was that the individual midwife became empowered by an increasing trust of herself, her own skill and her knowledge. Two midwives made the connection between trust of self and increased experience of intuition during the interview. One interview provided an opportunity to explore how the midwife's trust in herself was affected by an event. The midwife described an event that she had only previously related to a few people for fear of ridicule and misunderstanding. The midwife was unaware of the cognition governing her experience and related the story to me when I asked whether she had ever heard voices or seen visions. It is recalled here from the Findings in Chapter 4. The midwife was travelling to the birth of a woman having her second baby. The pregnancy had been easy and the woman and baby had been well. The midwife arrived at the house after an hours drive through traffic and had been aware of an increasing anxiety about getting to the house in time. During the drive she experienced a 'vision' of a Scottish woman who assured her that everything would be alright. On arrival all was well but the baby was in a breech position. The midwife felt a strong intuitive sense that everything was fine and was reassured when she remembered the Scottish woman's words. The baby was born safely whilst awaiting the ambulance.

Even though this was a unique and unexplained experience for the midwife she stated that she felt more invested in 'listening' to her intuition and trusting it as a result. This narrative

provides an interesting discussion around the cognition of intuition and the experience of fear that inhibits trust of oneself. Bastick (2003) calls this phenomenon a 'visual fantasy'. These fantasies are frequently created by the mind in an attempt to resolve anxiety. He explains that the processing of information is global (involving all aspects of memory including perceptual memory), non-linear and multimodal (characterised by several different modes of activity and occurrence). Therefore the secretion of adrenaline in response to anxiety and fear provokes a cognitive resolution in order to continue functioning.

Anxiety signals a potential threat that requires an adaptive response. This means that during an attempt to reduce anxiety and fear and to stabilise hormone fluctuations that inhibit cognition and may endanger the individual, the brain sources established emotional sets that have been developed from previous problem-evoking anxiety producing situations and combines them with global knowledge built up during the life of the individual. The combination of global knowledge and emotional sets occurs in the brain with the efficiency of a multichannel search for association and recall in order to reduce the anxiety and provide solutions or 'order' out of chaos, adrenaline subsides and the individual can think and act as required without the inhibitory effect of fear (Bastick 2003).

As adrenaline subsides neurotransmitters are released that enable cognitive function to accelerate allowing focus and action should it be required for survival or the resolution of a threatening situation (Kandel 2006). The resulting cognitive search for global information relating to the situation allows the brain to comfort the conscious mind by producing a 'vision', 'fantasy,' auditory experience or intuition (Bastick 2003). The cognition that allows the brain to manufacture a comforting hallucination subdues adrenaline whilst the brain searches for non-conscious solutions to the situation at hand. The solution may present as intuition or a new idea or insight into the presenting problem. In this way, the brain links the natural world of the individual with its understanding of the intimate memories and stored information of the individuals mind and experience and maintains survival (Bastick 2003; Kandel 2006). This is cognitive adaptation at work, and within a neuroscience framework, shows excellent cognitive function, however within a social network the midwife was concerned that she would sound 'crazy'.

Kandel's (2012) work extended on Bastick's identification of the intuitive response by showing that intelligent memory (intuition) will be prevented when the brain cannot resolve anxiety early in the process of matrixing neural connections (Duggan 2007; Kandel

2012). When anxiety escalates, neural pathways are blocked and fear becomes the dominant emotional response. The midwives all described fear as the 'enemy' when attending women in childbirth because they understood the visceral experience of their thinking, judgement and intuition being blocked without knowing the biology of the cognition underpinning it. The literature attests to the final intuition, which emerges into consciousness in a complete form when the brain is able to access global knowledge early in response to anxiety. This process is accompanied by feelings of confidence, trust and a lack of anxiety (Bastick 2003; Duggan 2007; Kandel 2012).

The midwife relating this story had practised for more than 25 years, her experience that day was far from 'crazy'. Rather, it showed the depth of her midwifery knowledge and the range of her life experience which enabled her brain to develop an elegant solution that achieved a reduction in adrenaline and anxiety and permitted her to safely problem solve once she had arrived at the birth. The fact that her brain developed a maternal Scottish mother figure to achieve the solution cannot be explained by Bastick or Kandel and may require a Jungian reference; however as a result of this experience the midwife reported both an immediate change in her confidence and a more permanent change in her trust of herself and her intuition. Berg and Dahlberg's (2001) Swedish study and Olafsdottir's (2006) Icelandic study provide an interesting cultural contrast to this midwife's fear of condemnation around her 'visitation'. Both studies give examples of midwives visual, auditory and sensory fantasies in connection with intuition. Furthermore, it appears to be culturally expected that an expert midwife would have access to a metaphysical source of information that enhanced her knowledge and contributed to her skill. The authors report this as part of the spiritual respect for 'other' knowledge that is culturally inherent in the northern hemisphere.

The midwives related stories about their recognition that they had found it necessary to trust themselves more and fear less. These discussions revolved around issues of disempowerment and women, subordination and midwifery, marginalisation and knowledge. An examination of that particular midwife's experience has allowed us to consider the debilitating effects of fear on private midwives working outside the dominant paradigm and the delicate acuity of the informed brain at work to produce intuition within a neuroscientific framework. The next section of the discussion addresses the study's second theme, knowledge.

### *Terra Incognita: An area of knowledge yet unknown*

The midwives in my study expressed the idea that midwifery knowledge belonged to the environment in which the midwife worked. All the midwives believed that unique midwifery knowledge had become subsumed by institutionalised childbirth and that midwives' knowledge has become embedded in obstetrics and more recently, in technology. One midwife described herself as a 'hospital refugee' because she needed to escape the affect of the system on her midwifery practise. They also expressed the idea that organisational routines, practises and norms had diluted 'real', woman centred midwifery care into time slots, routines and the standardised management required for processing large numbers of women efficiently. This was reflected in comments made by several midwives about the affects of standardised care on both the women receiving care and the midwives delivering care.

The midwives standpoint has developed through interplay between two discourses of knowledge; their tertiary education that is responsible for the development of clinical, scientific knowledge; and 'other' knowledge that is developed within the community of private midwives. This second knowledge is used, discussed, shared, passed on and taught informally. The first knowledge has a professional and an institutional function and constitutes essential knowledge for the performance of tasks required by the institution to; regulate skills, standardise care and maintain clinical support for the dominant medical structure that 'manages' normal and complex pregnancies and childbirth in Australia. In their study, Blaaka and Schauer (2008) found midwives described two distinct, subjectively derived knowledges – the biomedical model forms the dominant source of information and subjugated to that knowledge is midwifery knowledge. They describe midwifery knowledge as; sensory, relational and knowledge that is perceived as less rationactive (rational, logical). One midwife in my study expressed her need to '*not know*' in order to care for women individually. She believed that assumptions about women and birth, learnt whilst caring for women within a biomedical model, had distorted her ability to care for them in an individual way. She believed that allowing a labour to unfold, in a non-linear way, rather than forcing labours to conform to patterns controlled by interventions, reduced physical and psychological harm to the mother and the baby.

The second knowledge constitutes a body of information that is both intellectual and experiential. Some of this knowledge would only be utilised in private midwifery, as it requires skills that are developed where there are no institutionalised time constraints or

progress requirements placed on women during labour and birth. This results in the development of skills relevant to the context of private midwifery operating outside standardised institutions of care. This form of autonomous practice may transform the 'consciousness' of midwifery but it appears to embody a different view of women. This view perceives pregnant women as well women undergoing normal physiological changes during pregnancy that will culminate in a normal birth unless the pregnancy or labour deviates from normal and they require specialist obstetrical referral for more complex care and management.

The midwives all believed that intuition was unique knowledge for three reasons; it resides within the individual midwife, it is a product of their individuality in terms of learning, experience and memory and the midwife has complete ownership of her intuition. Ownership was an important feature and reflects the disempowerment the midwives experienced within the institution. Many of the midwives described a need to '*escape', 'get out'* and '*survive*' the institution and the biomedical model of midwifery required by it.

The midwives' comments about the dominance of institutionalised care and the biomedical model raises questions about midwifery education. Does the current system partly function to inculcate environmental work, relevant knowledge and behaviour that influence its reproduction in the workplace? Knowledge management theorists state that organisational knowledge is created and maintained by ongoing modelling and experiences (Noneka et al 1997). Educational theorists (Eraut 2000) argue that within the institution, both incidental and informal experiences account for the strongest learning processes that reinforce explicit knowledge. The implication is that, regardless of how we educate midwives, the development of their professional knowledge and the socialisation of their midwifery behaviour will be developed and reinforced within the institutions they work. Therefore midwives employed by institutions where midwifery knowledge is only meaningful and legitimate when it is supportive of and secondary to obstetrical, medical knowledge, will fail to develop their own thinking apart from those more powerful than them.

However, implicit knowledge and intuition or intelligent memory, is being created all the time, being shaped by midwives experiences, memories and knowledge synthesis. The work environment was critical for the midwives in this study who rely on intuition as a primary source of authoritative knowledge. This makes private midwifery a revolutionary act in a culture that grants conceptual and legal legitimacy only to logical reasoning and rational thought. The study participants valued multiple forms of authoritative knowledge without

devaluing nonrational ways of knowing. Whilst doing so they implicitly challenge the biomedical hegemony and reliance on scientific ways of knowing that they believe characterises and dominates the current approach to childbirth in Australia. They expressed the view that a medicalised approach is now the preferred model for hospitals, medical staff and midwives. This is borne out by women themselves who are increasingly adopting medicalised childbirth as normal and electing to be part of the public narrative of hospitalised management of pregnancy and birth (Lane 2006).

The private midwives emphasise a co-construction of authoritative knowledge with their clients about childbirth. Information is shared and the midwives have synthesised formal learning, biomedical knowledge about available technologies, midwifery expertise and multiple ways of knowing including intuition to form a midwifery epistemology that supports midwifery. They have effectively transitioned from institutional dependence to personal, professional independence. Belenky et al (1986) identified the transition from dependence on external authorities to an adoption of subjective knowledge as a major developmental transition, marked by a sense of personal strength and power where women become their own authorities.

All the midwives discussed their knowledge acquisition after leaving the hospital model of care as connected to a sense of personal power and agency. The midwives explicitly claimed knowledge as power and knowledge sharing, as empowerment. The ubiquitous connection between knowledge and power echoes Foucault's argument that knowledge and power are synonymous terms (cited in Huckaby 2008, p. 177). Pregnancy and birth are significant contributors to hospital culture and dominant knowledge disciplines and the inseparable nature of knowledge and power surrounding the management of pregnancy and childbirth directly increases the power of that discipline (Kitzinger 2005; Jordan 1993; Belenky et al 1986). The private midwives in my study elected to leave the hospital system due to a lack of control within institutionalised maternity care. Three had returned to teaching and casual work for two reasons; in order to maintain their hospital specific knowledge and skills and; to supplement their income. Their experience of the control of their professional knowledge makes expressing a self-defined midwifery standpoint most difficult. A female, private midwifery standpoint incorporating midwifery knowledge based on experience and intuition becomes an independent, viable, yet subjugated knowledge.

The formation and articulation of a midwifery standpoint appears to be key to the survival of private midwifery. As Audre Lorde (1984) argues, *'It is axiomatic that if we do not define*

*ourselves, we will be defined by others - for their use and to our detriment* ' (cited in Hill-Collins, 1991, p. 21). However, as the history of feminism has shown oppressed groups and female minority groups, particularly private midwives, inevitably must struggle to convey self-definitions because they are positioned at the periphery of the dominant white male culture of obstetrics and its policies (Morrison 1984).

Typically, policymakers take control of the procedures and determine how and when things will be done. In doing this they reinforce the old hierarchy of power, placing greater emphasis on the disciplines at the top, namely, the medical profession and science of the existing hierarchy (Lane 2006). In practice, this means that they push other disciplines such as midwifery and their authoritative knowledge even further to the margins of education and policy making. This made it necessary for the study midwives to unlearn practices that had been policy driven within the institution and focus on midwifery knowledge that would serve them in private practice where women relied on their unique skills devoid of machines and technologies and hierarchical structures that monitor progress, provide chemical pain relief and conform childbirth to norms, policies and procedures. One midwife expressed it as needing to *'unlearn'.*

### *Only by Unlearning Comes Wisdom*

The midwives described a process of unlearning hospital behaviours, including fear about childbirth, in order to learn to rely on intuition as a valuable resource in private midwifery. Intuition and the process of cognitive matrixing, allows for creative, unique, individual solutions to both clinical and non-clinical situations. The midwives repeatedly spoke about the importance of working with women as individuals with unique needs during childbirth and the negative impact that institutional behaviour had imposed on their ability to behave in an autonomous, innovative and individual way in their practise of midwifery within the institution.

Midwives are necessarily resourceful because childbirth is unpredictable, simultaneously emotional (fear, neurology and resilience) and physical (hormones, strength and fatigue). The midwives considered intuition a necessary resource because it is developed individually and occurs as an innovative response to a flood of information. Current neuroscience describes this neural activity of collecting information as 'stimuli'. The unlimited sources of information act as stimuli because they accumulate over an individual's lifetime and initiate

a cognitive response (Bastick 2003). The combinations of conglomerate 'stimuli' comprised of cognitive, motor, spatial, visceral, hormonal and emotive responses are the coded information for the intuitive response (Bastick 2003; Duggan 2007; Klein 2003). However an innovative response is often not considered 'good practice' in busy obstetrical units where efficiency and control are valuable (Lane 2006). The midwives had to unlearn institutional cynicism about the process of birth and a distrust of women's bodies and they all reported that they had to learn to use their intuition once out of the institution.

Odent (2012) states that the best way to provide excellent maternity care is to personalise it not standardise it. In order to do this Kirkham (2000) suggests that midwives need to protect their profession and discover their individual talents. Intuition is an aspect of midwifery knowledge that is both individual and personal because, as the literature has established it is dependent on individual experience, relationship and trust rather than standardised measures of risk assessment and policy. The Australian College of Midwives states that excellent midwifery knowledge is essential for the health of our communities (ACM 2008). Education is supposed to be the process that develops all resources but often it is not. An Australian study investigated 'midwifery as a profession in transition' and identified that hospitals exert a medical bias in terms of language, smell, colour, dress, design, culture and socially embedded rules (Lane 2006). This culture is imposed on women, well or otherwise, but it is also imposed on midwives. Regardless of a midwife's education she has to adapt to and survive the hospital culture once she is employed. The midwives in the study all underwent a process of unlearning hospital cultural practises in order for their intuition to be valuable and accessible.

The midwives in my study argued that their knowledge and skills are irrelevant within the hospital culture and only become valuable where women are well and birth without the use of chemicals and epidurals, mechanics and technologies that change the course of labour and complicate the birth outcomes. Winter (2002) found that the midwives in her study had developed a complex and diverse range of knowledge and skills working outside the institution and without the constraints of medical timeframes and institutional protocols that standardise care. Downe, Simpson and Trafford (2006) concluded that maternity models of care that limit the capacity of expert midwives to use their knowledge and skills, including intuition, within the dominant medical paradigm may not deliver optimal midwifery care. They linked intuition to expert, non-medical intrapartum care that was only provided by midwives and called for a re-valuing of intuition as critical to maintaining expert

knowledge (Downe, Simpson & Trafford 2006). The removal of the midwifery knowledge that can support women without drugs and technologies will effect new midwives' attitudes and skills and further contribute to the divide that exists between midwifery models and obstetrical models of care. Perhaps a way forward is to increase the presence of normal childbirth and midwifery care by increasing the number of midwifery- led models of care. These models promote a wellness focus and contribute to the perception of pregnancy as a normal, well stage of life, as it is for the majority of women, that requires expert, midwifery care, not medical, obstetrical, management. These models also provide an essential midwifery resource for women who do not want their childbirth managed medically unless it is required, ensuring that they have choices as well as greater control surrounding their care. The extension rather than the reduction of midwifery services for well women challenges the defensive litigation oriented practises currently driving hospital management of pregnancy and birth (Odent 2012). However, as Huckaby states:

> *Hidden knowledge, once it re-emerges, can alter the relations of power and make those forms of knowledge that have dominated, vulnerable (2008 p. 323).*

Without increasing midwifery expertise, normal birth and the visibility of midwifery knowledge as well as the subsequent validity of midwifery skills could become further diminished and irrelevant. This is about the heritage of midwifery in the Australian context. It has been established that intelligence is diverse, dynamic and distinct, involving emotion and intuition; therefore it could be argued that midwives need to be encouraged to develop their skills and their profession by utilising their full intelligence (Gardner 1993). Intuition then becomes part of intelligent behaviour and a midwife's experience becomes a valuable resource.

My study highlighted a difference in the midwives' confidence in their intuition that appeared to be relative to their years of practise. The following section discusses the midwives use of experience as knowledge and the divide between the midwives with more experience and those with less.

### *The Crone: Well behaved women seldom make history*

During data collection I became aware of a difference between the less experienced midwives reporting of their use of intuition and the very experienced midwives reports. As discussed in the Findings there may have been an 'insider' affect exerted by my appearance

and demeanour (older, researcher midwife) during the interviews that was unconsciously intimidating for the less experienced midwives but was innocuous during interviews with older, very experienced midwives. Nevertheless, the less experienced midwives justified their use of intuition as a secondary source of knowledge and wanted me to understand that they did not rely on it at the expense of their clinical knowledge. In doing so they exhibited the hierarchical attitudes of the institution toward intuition and manifested some of the authoritative devaluing of midwifery knowledge that has historically contributed to midwives feeling disempowered. They unknowingly aligned their unconscious assumptions about intuition as legitimate knowledge with the dominant medical hierarchy that they have rejected and separated from in order to practise privately. They also deferred to me. When describing their use of intuition the less experienced midwives inserted 'checking speech features' (Silverman 2010) into their dialogue. For example phrases such as '*Is that ok?', 'Do you think?'* and *'I don't want you to think that I would*....' were used to assure me of their safe practise and clinical knowledge.

The same midwives described fewer occasions of intuition and reported less confidence in their intuition. The less experienced midwives initially displayed discomfort through reticent body language and cautious communication around intuition. On reflection, I think they were hesitant to put themselves in a position where they could be negatively judged by a system that has devalued their intimate approach to midwifery and midwifery knowledge. Perhaps the less experienced midwives sought to protect themselves and their intimate knowledge from transparency and potential criticism. Once I became aware of their caution I had to remember that these less experienced private midwives were isolating themselves professionally from the dominant models of care and credibility in order to practise midwifery. They had learnt to become careful when exposing themselves to social, political and professional ridicule. One of the less experienced midwives expressed the emotion behind her reticence explaining that she had become '*very, very careful'* when talking about her work. Despite any initial hesitation, the midwives described a professional sense of isolation from 'the system' as a positive attribute of marginalisation as it protected the midwives from unwanted supervision and control and reduced any criticism of their practice.

The more experienced the midwife, the more comfortable she was describing her use and trust of intuition as a reliable, legitimate 'way of knowing' (Belenky 1986). The very experienced midwives associated the longevity of their experience and their confidence in

the correctness of their intuition with a diminished need to check, confirm or consult regarding intuitive ideas and practises. The less experienced midwives expressed that they might wait longer to act on their intuition, check with another midwife or consult before using their intuition in a situation. A degree of anxiety regarding working outside the mainstream institution might contribute to less experienced midwives confidence in talking about their intuition.

Bastick (2003) showed that empathy relates past experiences with present experience and Kandel's (2012) research into neurotransmitters extended on Bastick's study to establish the neurobiological link between short and long term memory references, emotion, cognition and intuition. Bastick (2003) established a link between expertise, which was affected by years of experience and increased intuition. Within the literature, several of the research studies established a relationship between practitioners with a high emotional intelligence quotient (EIQ) and a preference for an intuitive cognitive style when working with clients at an expert level (Blaaka 2008; Downe 2004; Downe 2007; Fry 2007; Kennedy 2000; Rew 2001; Olafsdottir; 2011). Bastick (2003) established a relationship between high EIQ and intuition and Olafsdottir's study (2011) showed a significant relationship between years of experience and the use and frequency of occurrence of intuition among more experienced midwives. However, feminist literature identifies a parallel between a generalised increase in confidence and a woman's age (Parratt et al 2008; Wickham 2004). The more experienced midwives in the study were also more confident in their general demeanours. They reported that they would always listen to their intuition over their clinical assessment even when their intuition contradicted the clinical picture. Duggan (2007) argues that the human brain requires diverse experiences to acquire language, culture and what is learnt from others, formally through education and informally through watching, listening, odours, taste, touch and reading. The importance of experiential learning, for the development of intuition, was reported by the participants in Olafsdottir's work. One midwife expressed it by sweeping her hand down the front of her body as she said:

> *Look at me. I think with my body. And I've been living a long time. (Olafsdottir, 2002)*

This midwife was expressing the neurobiology that shows that the more experienced the midwife (or individual), the more synthesised her cognition will be, increasing her global

knowledge and therefore potentially, her experience of intuition (intelligent memory) (Kandel 2012).

Smith's (1987) feminist standpoint theory is relevant here as well. Central to standpoint theory are feminist analyses of relations between experience, power and epistemology and the effects of those power relations on the production of knowledge. Smith uses the notion of standpoint to emphasize that what one knows is affected by where one stands (one's subject position) in society. Smith argues that '*women's work conceals from men the actual concrete forms on which their work depends'* (1987, p. 83–84). If epistemology is the science of perceiving knowledge, it is obvious that women (midwives) have a case for establishing their own epistemology. Several authors (Duran 1995; Harding 1987, 1989; Smith 1992, 1996) reflect this view and write forcefully about this concept as though it were correct and legitimate. This is true of the midwives in Blaaka and Schauer (2006), Berg and Dahlberg (2001), Davis-Floyd and Davis (1997), Kennedy (2002), Winter (2002) and my own study who all reported degrees of intellectual shame and professional frustration about the scientific illegitimacy of their intuitive knowledge whilst caring for women within the institutional setting. Interestingly Olafsdottir's (2006) study contradicted these findings and revealed a professional and social valuing of midwives' intuition in Iceland. Within the institution, the more experienced midwives were expected to have developed and use intuition gained through years of experience. Olafsdottir relates this to the more spiritual culture of Iceland where intuition is elevated knowledge and associated with accessing a metaphysical realm. Again, the midwives 'standpoint' within the Icelandic culture has resulted in a super-valuing of their intuition and unique knowledge.

The Icelandic study was distinctly different to Davis-Floyd and Davis's (1997) American study where the midwives believed they were perceived as 'backward' and 'naive' to use intuition as a source of knowledge. Smith's (2005) particular approach; Institutional Ethnography, is a method of elucidating and examining the relationship between everyday activities and experiences and larger institutional imperatives. Smith emphasises that pragmatic performance constitutes the everyday world and in doing so reaffirms the existing structural order. For example, it is only because of the hospital midwife's internalised, taken-for-granted beliefs about class, property, prestige, knowledge and authority that mean they know how to behave within the institution. However, the private midwives 'standpoint' reflects the specific attitudes, emotions and values that a female,

private midwife experiences and internalises at the level of the individual and the work culture rather than acclimatisation to the ruling structures of the organisation.

Smith's (2005) concept of the bifurcation of consciousness is also relevant here. It describes that subordinate groups are conditioned to view the world from the perspective of the dominant group, since the perspective of the dominant group is embedded in the institutional practices of that world. The subordinate group must continually accommodate themselves to the dominant group in order to gain acceptance in a world that is not theirs, using knowledge that is not theirs, members of the oppressed group become alienated from their 'true' selves.

This notion was articulated by midwives in Davis-Floyd and Davis (1997), Winter (2002) and my study, when midwives defined differences between hospital and private midwives. Value laden terms including 'true', 'real', 'authentic', 'full', 'complete', 'bona fide' and 'kosher' midwifery were used to distinguish the private midwives from 'hospital' midwives who were perceived as having 'given up', 'given in', 'let go', 'thrown in the towel' and subjugated their ideological midwifery standpoint by conforming to a biomedically focused, institutional employer. It is apparent that an institutional cultural element may exist here. Berg and Dahlberg (2001) and Kennedy (2002) both conducted studies with midwives working within institutions who were identified as 'expert' in their field. Berg and Dahlberg found that the midwives using intuition were perceived as having a 'superior, developed capacity' that was aligned with a high level of expertise. Kennedy reported that midwives using intuition were '*more sensitive'* to women in their care and displayed '*superior'* skills when dealing with the changes and intensity of caring for women during childbirth. The midwives in my study communicated significant pride in their ability to work 'with women' during childbirth, without the use of drugs or technologies. They found that their knowledge and skills had become refined, more sensitive and deeper from their private practices. None of the midwives desired a future in the hospital setting.

## Limitations to the Study

This study, like all studies, has a number of limitations. Although the sample size is representative of private midwives practising in NSW at the time the study was conducted, it is small and cannot be generalised to the broader population. The study was conducted within the Sydney metropolitan area and therefore does not represent Australian private

midwives generally. The study is also limited by being a Masters Degree undertaken over the course of four years and has restricted the size and strength of the study.

Initially I intended to use Bastick's (2003) 20 properties of intuition in order to categorise and code the data and compare the findings with Kandel's (2012) work on Intelligent Memory. However, by interview five I was experiencing what Silverman refers to as '*the uncertainties and ambiguities of social research'* (2010 p. 95). I could not make the categories fit the data that was emerging. Bastick's study increasingly appeared to provide more researcher-provoked data that was not exploratory enough for the naturalism involved in the study being undertaken. It became apparent that in order to utilise his categories I would need to replicate Bastick's study, using his questions. As Bastick's was a mixed method study he collated the question and response data quantifiably which resulted in the identification of 20 properties of intuition in that study. Because this was not appropriate for the research I was undertaking I abandoned them. I have concluded that in order to compare Bastick's properties a different study is necessary. A study using Bastick's own questions, a larger group of midwife participants and a mixed method approach may yield comparable results in which his 20 properties could be used for analysis. However it may be at the expense of the naturalistic, descriptive data that was collected in this study. I have attempted to use Bastick's (2003) and Kandel's (2012) work as they related to the findings. This overlay of the sciences has made for complex and interesting interpretation of the data.

A limitation of the study that became evident during data collection was that none of the midwives had thought about what intuition was and how they used it prior to being interviewed. Whilst this allowed for the capture of unrehearsed, spontaneous thought it revealed the limitations of language when describing unlearned or undeveloped concepts. Historically, language has limited the description of intuition and yet I was expecting the participants to overcome the restriction of describing what we don't know. The midwives consequently struggled to convey their thoughts. This had a twofold effect; some midwives spoke more furiously and longer to convey their meaning and some midwives became self-conscious and shy about a perceived difficulty in articulating their thoughts in the interview construct. On reflection, incorporating a focus group into the method where midwives having difficulty could be more 'absorbed' by a group and their thought processes stimulated whilst more confident speakers initiate discussion might reduce this effect.

With relation to the limitations of language and the communication of unconscious ideas I now consider the data collection method insufficient to capture thick description of the midwives use of intuition although it has been appropriate in the context of this study. Another study, using a larger cohort of midwives who maintain a diary documenting occurrences of intuition and their thinking about intuition for six months following the initial interview would allow them to raise their consciousness, develop their thinking and record the events in real time. This method could potentially produce thicker, richer data for analysis.

As the study proceeded, the midwives' standpoint started to weigh on discussions surrounding professional oppression and institutional ethnography. As these issues manifested I considered whether the urban demography of the participating midwives had a socialising effect that limited the interpretation of midwives use of intuition. In Sweden and Iceland, midwifery is largely autonomous and considered a vocational not a biomedical or scientific profession. The authors Blaaka and Schauer (2006), and Olafsdottir (2006), reported that intuition was associated with a high level of midwifery expertise. Prior to my study, I made the assumption that expert midwifery practice with 'low risk' women was the property of private midwives and proceeded to investigate their practises. Whilst it was practical to focus on a specialised group for the purpose of this study, a larger study of intuition might be able to draw meaningful contrasts between midwives working within and midwives working outside the institutions providing care. A study of this nature may also contribute to understanding whether intuition will manifest where technologies are relied upon. This is of increasing significance as the technologies supporting pregnancy and childbirth become normalised for low risk women and midwives use fewer midwifery skills including intuition and increasingly use technologically based skills.

Despite these limitations, the study has enabled the development of ideas about social and cultural processes that are relevant beyond the data and, consequently has been a useful investigation into private midwifery practice and intuition within an Australian context.

## Summary

The discussion has attempted to show the extraordinary insight of midwives and their stories about intuition in this and the other studies presented in the literature. Analysis has provided insight into the understanding and practice of intuition by these private midwives.

In 1993, Leap described midwifery's particular knowledge: *'Our expertise as midwives rests in our ability to watch, to listen and to respond to any given situation with all of our senses.'* (p. 169, (Leap & Hunter 1993). Leap's sentient words illustrate the midwives' descriptions of their practises and the idea that we acquire knowledge of the world by experiencing it, through contact with it, is reflected in their experiences of intuition.

By using current neuroscience I have provided a framework for examining the cognition underpinning intuition. The link to neuroscience and intelligent memory is important because it elevates experience and holds authority as a ground for speaking and daring to speak truthfully. It challenges the rational and objectified forms of knowledge associated with our health institutions. Narrating their experiences has been a means of discovery for the midwives as participants and for me as a researcher. What we did not know and did not know how to think about I have been able to examine as they spoke of the common ground of being with women during childbirth. The interviews revealed that the midwives believed that only in a culture where a midwifery model of care was primary and valued would midwifery knowledge be the dominant epistemology.

The midwives interviewed for this study made a decision to practise privately as a way of safeguarding their knowledge and skills amongst colleagues and women who valued them, away from an institutional culture that emphasised management, action, instrumentation, technologies and biomedical skills for normal, well women having normal, well babies. The midwives all associated effective midwifery care with relationship, knowledge, skill and intuition. All the midwives interviewed for this study and the studies in the literature, believed intuition to be a unique and vital component of a midwife's knowledge and expert skill. The study showed that intuition was more evident in a calm environment where the woman's locus of control was undisturbed and where relationship had been developed between the midwife and the woman and trust was reciprocated. These midwives and all their experiences are the voices that will assert the subjugated woman and the threatened role of authoritative midwifery knowledge within and outside our institutions.

# CONCLUSION

### *Searching for meaning*

This study has investigated the professional lives of a sample of Australian private midwives who described skills expressive of intuition and values that embody trust, relationship and knowledge in their practice of midwifery. Their stories offer a vividness of recall that is associated with intense emotion and as the literature has shown, emotion and intuition are linked by the cognitive function of memory. Intuition has been examined within a neuroscience framework that has offered an explanation for it in terms of intelligent memory, an association that was not found in any of the literature. This research has contributed to the existing body of knowledge about intuition and significantly to our understanding about Australian private midwives and intuition. As has been discussed; intuition is a combination of intricate conscious and unconscious neural activity that has been enlivened by personal attributes and environmental contexts. Other, nuanced attributes that affect the expression of intuition include power relations and a sense of trust, security and confidence. This study has shown that emotional maturity and a developed sense of 'self', as well as years of practice were found to have a significant affect on both the occurrence of intuition and the midwives confidence in it. The relationship between ages, years of practice and personal maturity appears to be information that has come to light in this study.

The literature showed how knowledge systems and ways of knowing are influenced by culture and belief and compared the studies done in the northern hemisphere with my research. Culture and belief systems influenced the methodology for my study and highlighted the differences between the other studies where intuition was perceived as a spiritual 'gift' available to experts and 'knowers' of secrets that was associated with a metaphysical experience. The current neuroscience literature offers a cognitive method for analysing and discussing the neurobiology underpinning intuition; a phenomenon that we might otherwise be unable to understand in the context of midwifery. This study fills a gap in the literature by providing a link between intuition and midwives,' intelligent memory' and neuroscience. Where the existing literature has explored midwives experiences of intuition, my study extends on that research and suggests a neurobiology of intuition that is cognitive rather than metaphysical. This link was not found in any other literature and indicates a cultural departure from a spiritual or metaphysical relationship between midwives and intuition toward a cognitive approach.

The midwives who participated in this study remain unaffected by such information. They are assured of the value of their intuitive practises by the birth outcomes of the women they attend during pregnancy, labour and birth and do not require a scientific legitimisation to verify their intuition or its value. However my study has contributed to an understanding of Australian private midwives contribution to midwifery practice by increasing our knowledge about their insight into and use of intuition as well as the phenomenon itself. The midwives expressed the importance of experiential learning that contributed to their intuition – a term difficult to deconstruct. The most dramatic examples and experiences of problem solving were remembered, especially those involving memorable mistakes and 'good' intuition. The location of memory is limbic, not neocortical, and therefore may lack language construction and conscious memory of the experiences and situations involving intuition and so they 'sense', 'feel', 'know' and have the confidence to act on their intuition; their unconscious knowledge. This demands reflection, analysis and imagination where group or mentored learning could possibly give language to what can be identified and made conscious. As a result, ongoing workplace situated learning could be potentially valuable for the transference of 'real' skills. These findings have assisted in refining the exploration of intuition in midwifery practice. Midwifery education could benefit from these findings by assisting midwives to reflect on practises that are intuitively derived. Midwives within our institutions should be encouraged to debrief, communicate skills and share knowledge that is related to their intuition, and management systems should allow midwives time to demonstrate intuitive attributes and skills in daily practice in order to protect this aspect of midwifery epistemology.

My study indicated that the midwives practising outside the dominant models of Australian maternity care have chosen a private model of care to escape entrenched attitudes toward authoritative midwifery knowledge within institutions and the power hierarchies that exist therein. With midwifery education influenced by an institutional biomedical model that engenders the belief that well women are at great risk during childbirth, the institutions role has focussed on avoiding litigation. This has been achieved by creating a culture of risk avoidance for all women rather than a culture of risk management for women who want to make informed choices about their care and options for treatment and the management of issues. These issues resonated with the American studies where vertical hierarchies have established a culture of disempowerment amongst midwives and their knowledge. The findings in my study suggested that limitations of institutional policies and protocols created a distraction from the development of intuition and limited the opportunity for it to

be used in the care of women during childbirth. As the literature and the discussion have shown, intuition will flourish in the environment that private midwives practice in, away from a biomedical, risk averse management of childbirth for well women and babies.

The study midwives all practised from the perception that pregnancy and childbirth will be normal until it proves otherwise or falls outside of established, normal health parameters. Consequently, the model of care and the environment of practise become influential in determining both the practises and the perceptions of risk within that environment. In a medically constructed institution, a context of defensive practice drives management and decision-making and employees, such as midwives, lower down the vertical hierarchy, who are subordinate to the ruling structures of the organisation, become subjugated. The greater the perception of risk, the more interventions will be used to modify risks and reduce fear of litigation. Whereas, my study suggested that in private midwifery and a context of normal, healthy pregnancy conducted away from the institutional norms, midwives are more autonomous and midwifery knowledge becomes the dominant resource for care during pregnancy and birth.

The study shows that it is difficult to develop a clear understanding of how intuition is incorporated into midwifery practise. The midwives in my study themselves had limited understanding of their experiences of intuition. Although they were able to communicate a complex matrix of knowledge, skill and emotional and physical experience that complimented their practises, it was difficult for them to realise and describe something that was unconscious and previously unexamined. The study also showed that intuitive practises are associated with increased relational and emotion work with clients, affording them greater satisfaction and less standardised care.

In the future, information sharing and less authoritative models of care may be required by informed women with greater expectations of control and negotiation about their health care. Participatory health care models could be used to link personalised data with the midwife. If this does occur, women's data could be useful to investigate and analyse issues regarding the occurrence, frequency and use of intuition; how it changes care or outcomes and how we measure it occurring. My study did not investigate the women's perception of care associated with intuition but further research on this issue could provide valuable feedback for the further assessment of women's satisfaction and intuitive midwifery skill.

The midwives in my study described both exemplary practise models and sophisticated knowledge systems that incorporated intuition. It has been shown that intuition enhances midwifery practise and client satisfaction rather than detracting from the scientific rigour of best practice. Intuition is inherently valuable for midwives in private practice and we need to consider whether it has a broader, valuable application. I have used current literature to argue that intelligent memory allows a complex cognitive layering of synthesised knowledge that contributes to a midwifery epistemology. The implications of a benefit to midwives through practise, education and learning and the reported increased satisfaction for women receiving care lie in midwifery education and training. Therefore, can we afford to lose intuition as a legitimate knowledge source and how do we keep this knowledge and these skills within our systems in an environment of overt obstetrical governance? Midwifery academics (Davis-Floyd 2001, Kirkham 2005; Downe 2006) argue that strong midwifery leadership and feminist principles need to be enacted to change the current hospital culture and to empower midwives within it. Further research regarding intuition, modelling and mentoring is required to explore the future of midwifery education and intuition.

The midwives chose not to confront the institutional culture they found oppressive and have consequently removed their knowledge and skills from women and other midwives in the system. These midwives are participating in a sociological discourse that they believe privileges the women they care for. They are committed to a midwifery that is ontologically faithful, faithful to the presence and activity of a midwife's clients and faithful to the actualities of the world she lives and works in. The study identified that intuition is inherent in expert, midwifery practise and becomes liberated within a sympathetic environment. It has also attempted to identify Australian private midwives' use of intuition and restore its legitimacy as a source of knowledge, not alchemy. Neurobiology has provided a framework to understand intelligent memory and the cognition of intuition. This framework suggests that midwifery's epistemology and its education and training may benefit from remaining cognisant of developments in brain science for future research and learning.

# REFERENCES


Agor, W.H. 1986, *The Logic of Intuitive Decision Making: A Researched Approach for Top Management*, Quorum Books, New York.

Agor, W.H. 1991, 'How intuition can be used to enhance creativity in organisations', *The journal of Creative Behaviour*, vol. 25, no. 1, pp. 11-9.

*Australian Health Professions Regulation Agency"*, AHPRA, Report Edition 7, December 2012, [Online] http://www.ahpra. *"Annual Report 2011–12 for the National Registration and Accreditation Scheme. P. 74.*

Association of Australian Private Midwives, 2008. 'http://australianprivatemidwivesassociation blogspot.com.au'.

Australian and Midwifery Council 2006, *National Competency Standards for the Midwife*. Nursing and Midwifery Board of Australia Codes and Guidelines AHPRA, 2014. www.nursingmidwiferyboard.gov.au/

Australian Government 2007, *National Statement on Ethical Conduct in Human Research*, Australian Government, Canberra.

Australian Nursing and Midwifery Council 2008, *Code of Ethics for Midwives in Australia*.

Australian College of Midwives ACM, 2009, 'ACM Philosophy', in E.A.M. Department of Health (ed.) Online Database. http://www.nswmidwives.com.au

Australian Society of Independent Midwives. 1999, 'http://www.australiansocietyofindependentmidwives.com',

Bachelor, A. 1995, 'Clients perception of the therapeutic alliance: a qualitative analysis', *Journal of Counselling Psychology*, vol. 42, no. 3, pp. 323-37.

Ballen, L.E. & Fulcher, A.J. 2006, 'Nurses and Doulas: complementary roles to provide optimal maternity care.', *Journal of Obstetric and Gynaecological Nursing*, vol. 35, no. 2, pp. 304-11.

Barclay, L. 2008, 'A feminist history of Australian midwifery from colonisation until the 1980's', *Women and Birth*, vol. 21, no. 1, pp. 3-8.

Barclay, L., Brodie, P., Lane, K., Leap, N., Reiger, K. & Tracy, S. 2003, *Australian Midwifery Action Project*, Centre for Family Health and Midwifery - University of Technology, Sydney.

Bargmann, S. 1954, *Ideas and Opinions*, (translation of Einstein's 1936, 'Physics and Reality), Bonanza Press, New York.

Barnes, M. 1997, 'Research in midwifery - the relevance of a feminist theoretical framework', *Australian College of Midwives Incorporated Journal*, vol. 12, no. 2, pp. 6-10.

Barnes, M. 1999, 'Research in midwifery - the relevance of a feminist theoretical framework', *Australian College of Midwives Incorporated Journal*, vol. 12, no. 2, pp. 6-10.

Bassett, K.I., N. and Kazanjiian,A. 2000, 'Defensive medicine during hospital obstetric care: a by-product of the technological age', *Social Science and Medicine*, vol. 51, pp. 533-537.

Bastick, T. 2003, *Intuition: Evaluating the Construct and its Impact on Creative Thinking*, Stoneman and Lang, New York.

Beasley, C. 1999, *What is Feminism? An introduction to feminist theory*, Sage Publications, London.

Becker, H.S. 1996, 'The Epistemology of Qualitative Research', in R. Jessor, A. Colby & R.A. Schweder (eds), *Ethnography and Human Development: Context and Meaning of Social Inquiry*, University of Chicago Press, Chicago.

Belenky, M.F., Clinchy, B.M., Goldberger, N.R. & Tarule, J.M. 1986, *'Women's Ways of Knowing'*, Basic Books, USA.

Benner, P.E. 1984, *From novice to expert: Excellence and power in clinical nursing practice*, Menlo Park, California.

Benner, P.E., Tanner, C.A. & Chesla, C.A. 1996, *Clinical judgement in expertise in nursing practice: caring, clinical judgement and ethics*, Springer Publishing Company, NY.

Benoit, C., Wrede, S., Bourgeault, I.L., Sandall, J., DeVries, R. & van Teijlingen, E.R. 2005, 'Understanding the social organisation of maternity care systems: midwifery as a touchstone.', *Sociology of Health and Illness*, vol. 27, no. 6, pp. 722-37.

Berg, B.L. & Lune, H. 2013, *Qualitative Research Methods for the Social Sciences: Pearson New International Edition*, Pearson, Munich.

Berg, M. & Dahlberg, K. 2001, 'Swedish midwives care of women who are at high obstetric risk or who have obstetric complications.', *Midwifery*, vol. 17, no. 4, pp. 59-66.

Berry, R. 1986, *The research project. How to write it*, 5 edn, Routledge, London and New York.

Blaaka, G.S., T. 2008, 'Doing midwifery between different belief systems', *Midwifery*, vol. 24, pp. 344-52.

Bloomberg, L.D. & Volpe, M. 2008, *Completing your qualitative dissertation; Roadmap from beginning to end*, Sage Publications, Los Angeles.

Bolen, S.J. 2003, *Crones Don't Whine*, Conari Press, Boston.

Borbasi, S.J. & Langford, R. 2008, *Navigating the Maze of Nursing Research; an interactive learning adventure*, Mosby, Marrickville.

Boud, D.M., H. 2003, 'Learning from others at work', *Journal of Workplace Learning*, vol. 15, no. 5, pp. 194 - 202.

Bourgeault, L., Benoit, C. & Davis-Floyd, R. 2004, *Reconceiving Midwifery*, McGill-Queen's University Press, Montreal & Kingston, London, Ithaca.

Boxall, A.M. & Flitcroft, K. 2007, *From little things, big things grow: a local approach to system wide maternity services reform in the absence of definitive evidence.*, vol. 4:18, Australian and New Zealand Health Policy, Published online. Accessed May 23 2012.

Boyatzis, R.E. 1998, *Transforming Qualitative Information: Thematic Analysis and Code Development*, Sage Publications Inc., Thousand Oaks, California.

Braun, V.a.C., V. 2006, 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, vol. 3, no. 2, p. 93.

Burns, E.F., J. Schmeid, V. Sheehan, A. 2012, 'Reflexivity in midwifery research: The insider/outsider debate', *Midwifery*, no. 28, pp. 52-60.

Burns, N. & Grove, S. 2005, *The practice of nursing research; conduct, critique and utilization*, 5 edn, Elsevier Sanders, St Louis.

Burns.E, F.J., Schmeid.V,Sheehan.A. 2012, 'Reflexivity in midwifery research: The insider/outsider debate', *Midwifery*, vol. 28, pp. 52-60.

Cahill, H.A. 2001, 'Male appropriation and medicalisation of childbirth: an historical analysis.', *Journal of Advanced Nursing*, vol. 33, no. 3, pp. 334-42.

Cahill, L. 2005, 'His brain, her brain', *Scientific American*, vol. 292, pp. 40-7.

Carolan, M. 2006, 'Women's stories of birth: a suitable form of research evidence?', *Women and Birth*, vol. 19, no. 3, pp. 65-71.
Cassidy, T. 2006, *Birth: The Surprising History of How We Are Born*, Atlantic Monthly Press, New York.
Centre for Epidemiology and Research 2009, *New South Wales Mothers and Babies 2006*, NSW Department of Health, North Sydney NSW.
Charmaz, K.C. 2006, *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis (Introducing Qualitative Methods Series)* Sage Publications Ltd. Los Angeles.
Cheyney, M.J. 2008, 'Homebirth as systems challenging praxis: knowledge, power, and intimacy in the birthplace', *Qualitative Health Research*, vol. 18, no. 2, pp. 254-67.
Catling-Paull, C., Foureur, M. J. and Homer, C.S.E. 2013, 'Publicly funded homebirth in Australia: a review of maternal and neonatal outcomes over 6 years', *Medical Journal of Australia*, vol. 198, no. 11, pp. 616-20.
Comerasamy, H. 2001, 'The development of midwifery knowledge and its relationship to the curriculum: an investigation of two cases.', Abstract in PhD dissertation, University of Surrey.
Davis-Floyd, R. 2001, 'The technocratic, humanistic and holistic paradigms of childbirth', *International Journal of Gynaecology and Obstetrics*, vol. 75, no. Suppl 1, pp. S5-S23.
Davis-Floyd, R. & Arvidson, P.S. 1997, *Intuition: The inside story*, Routledge, New York.
Davis-Floyd, R. & Davis, E. 1996, 'Intuition as authoritative knowledge in midwifery and homebirth', *Medical Anthropology Quarterly*, vol. 10, pp. 237-69.
Davis-Floyd, R. & Johnson, C.B. 2006, *Mainstreaming Midwives: the politics of change*, Routledge, New York.
Davis-Floyd, R.E. & Sargent, C.F. 1997, *Childbirth and authoritative knowledge. Cross cultural perspectives*, University of California Press, New York.
Denzin, N.K. 2001, *Interpretive Interactionism*, Sage Publications Inc., Newbury Park, California.
Denzin, N.K. & Lincoln, Y.S. 1993, *Handbook of qualitative research*, Sage Publications Inc., Newbury Park, California.
Department of Health, 2011, *Department of Health, Education and Media,* viewed November 2011, <http://mhcs.health.nsw.gov.au>.
DeVries, R.G. 1993, 'A cross-national view of the status of midwives.', in E. Riska & K. Wegar (eds), *Gender, Work and Medicine: women and the medical division of labour*, Sage Publications, London, pp. 131-46.
Doidge, N. 2007, *The Brain That Changes Itself*, Penguin Books, Sydney, Australia.
Donnison, J. 1988, *Midwives and Medical Men: a history of the struggle for the control of childbirth*, 2 edn, Historical Publications, London.
Downe, S. 2006, 'Engaging with the concept of unique normality in childbirth', *British Journal of Midwifery*, vol. 1, no. 6, pp. 352-6.
Downe, S. & McCourt, C. 2004, 'From Being to Becoming: Reconstructing Childbirth Knowledge', in S. Downe (ed.), *Normal Childbirth: Evidence and Debate*, Churchill Livingstone, Edinburgh, pp. 3-24.
Downe, S., Simpson, L. & Trafford, K. 2007, 'Expert intrapartum maternity care: a meta-synthesis', *Journal of Advanced Nursing*, vol. 52, no. 2, pp. 127-40.
Drife, J. 2002, 'The start of life: a history of obstetrics', *Postgrad Medical Journal*, vol. 78, no. 919, pp. 311-5.

Duggan, W. 2007, *Strategic Intuition: The Creative Spark in Human Achievement*, Columbia University Press, New York.
Ehrenreich, B. & English, D. 2005, *For her own good: Two centuries of the experts' advice to women*, Vintage Random House Inc, New York.
Eisenhardt, M.a.Z., M.J. 1992, 'Strategic decision making', *Strategic Management Journal*, vol. 13, no. 52, pp. 17-37.
Enkin, M., Keirse, M., Neilson, J., Crowther, C. & Duley, L. 2000, *A Guide to Effective Care in Pregnancy and Childbirth*, 3 edn, Oxford University Press, Oxford.
Eraut, M. 2000, 'Non-formal learning and tacit knowledge in professional work', *British Journal of Educational Psychology*, vol. 70, no. 1, pp. 113-36.
Evenson, D. 1982, 'Midwives: survival of an ancient profession', *Women's Rights Law Reporter*, vol. 7, pp. 313-30.
Evenson, J.S. 1982, *Mentors and Students in the workplace*, National Institute of Education; Teaching and Learning Program, Washington DC.
Fahy, K. 2002, 'Reflecting on practice to theorise empowerment for women: using Foucault's concepts', *Australian Journal of Midwifery*, vol. 15, no. 1, pp. 5-13.
Fahy, K. 2005, 'Quality and significance of Australian midwifery research', *Australian Midwifery*, vol. 18, no. 1, pp. 8-15.
Fahy, K. 2007, 'An Australian history of the subordination of midwifery', *Women and Birth*, vol. 20, no. 1, pp. 25-9.
Finlay, L. 2006, *Researching Health: Qualitative Research Toward Public Health*, Milton Keynes, The Open University: Buckinghamshire.
Flint, C., Polly.P. 1986, *The 'Know Your Midwife' Report*, South West Thames Regional Health Authority, Wellington Foundation, London.
Fontana, A. & Frey, J.H. 1993, *Handbook of Qualitative Research*, Sage Publications.
Forgas, J.P. 1994, 'The role of emotion in social judgements: an introductory review ', *European Journal of Social Psychology*, vol. 24, no. 1, pp. 1-24.
Frank, A.W. 2000, 'The standpoint of storyteller', *Qualitative Health Research*, vol. 10, no. 3, pp. 354-65.
Freda, M. 1994, 'Childbearing, reproductive control, aging women and health care: the projected ethical debates', *Journal of Obstetrical, Gynaecological and Neonatal Nursing*, vol. 23, pp. 144-52.
Freidson, E. 1970, *The profession of medicine*, Mead and Co, New York.
Fry, J. 2007, 'Are there other ways of knowing? An exploration of intuition as a source of authoritative knowledge in childbirth', *MIDIRS Midwifery Digest*, vol. 17, no. 3, pp. 325-8.
Fullbrook, P. 2004, 'Realising advanced nursing practice through reflection', *British Association of Critical Care Nurses*, vol. 9, no. 6, pp. 255-6.
Gardner, H. 1993, *Frames of Mind: The Theory of Multiple Intelligences*, Basic Books, USA.
Gaskin, I. 1996, 'Intuition and the emergence of midwifery as authoritative knowledge', *Medical Anthropology Quarterly*, vol. 10, no. 2, pp. 295-7.
Gelbart, N.R. 1998, *The King's Midwife: A History and Mystery of Madame du Coudray*, University of California Press, Berkeley, Los Angeles, London.
Giorgi, A. 1997, 'The theory, practice and evaluation of the phenomenological method', *The Humanistic Psychologist*, vol. 34, no. 4, pp. 305-19.

Godfrey-Smith, P. 2007, 'Popper's philosophy of Science: Looking Ahead', in Shearmur.J. & Stokes.G. (eds), *The Cambridge Companion to Popper*, Harvard University Press.
Gordon, B. & Berger, L. 2003, *Intelligent Memory*, Viking, Penguin group, New York, USA.
Gould, D. 2008, 'Inverting the hierarchy', *Royal College of Midwives Journal*, vol. 8, no. 8, pp. 354-5.
Govier, T. 1992, 'Trust, distrust and feminist theory', *#ypatia*, vol. 7, no. 1, pp. 16-33.
Grbich, C. 1999, *Qualitative research in health: an introduction*, Allen and Unwin, New York.
Guiver, D. 2004, 'The epistemological foundation of midwife-led care that facillitates normal birth', *Evidence Based Midwifery*, vol. 2, no. 1, pp. 28-34.
Hall, J. 2001, *Midwifery, Mind and Spirit: emerging issues of care*, Books for Midwives, Oxford.
Harding, S. 1987, *Feminism and methodology*, Indiana University Press, USA.
Hill-Collins, P. 1986, 'Gender and Society', *Signs: Journal of Women in Culture and Society*, vol. 72, no. 3, pp. 444-59.
Hill-Collins, P. 1991, *Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment*, Routledge, New York.
Holloway, I. 2001, 'Revisiting qualitative inquiry: interviewing in nursing and midwifery research', *Nursing Times Research*, vol. 6, no. 1, pp. 539-50.
Homebirth Access Sydney 2011, *http://www.homebirthsydney.org.au*, viewed March 2012, <www.homebirthsydney.org.au>.
Homer, C., Davis,G., Brodie,P., Sheehan,A., Barclay,C., Wills,J. & Chapman,M. 2001, 'Collaboration in maternity care: a randomised controlled trial comparing community based continuity of care with standard hospital care', *British Journal of Obstetrics and Gynaecology*, vol. 108, no. 1, pp. 16-22.
Homer, C., Brodie, P. & Leap, N. 2008, *Midwifery Continuity of Care: A Practical Guide*, Elsevier, Sydney.
Homer, C.P., Brodie, P.L., Kildea, S., Leap, N., Pincombe, J. & Thorogood, C. 2009, 'The role of the midwife in Australia; views of women and midwives', *Midwifery*, vol. 25, pp. 673-81.
Homer, C.S.E. 2005, 'Laying the foundation: the STOMP study', *In Midwifery and Public Health: Future Directions and New Opportunities*, Churchill Livingstone, Edinburgh.
Hubble, M.A., Duncan, B.L., Miller,S.D. 1999, *The Heart and Soul of Change; What Works in Therapy*, The American Psychological Association, USA.
Huberman, A.M. & Miles, M.B. 2002, *The Qualitative Researcher's Companion*, Sage, Thousand Oaks, California.
Huckaby, M. 2008, 'Making use of Foucault in a study of specific parrhessiastic scholars', *Education Philosophy and Theory*, vol. 40, no. 6, pp. 770-88.
Hunter, B. 2001, 'Emotion work in midwifery: a review of current knowledge', *Journal of Advanced Nursing*, vol. 34, no. 4, pp. 436-44.
Hunter, B. 2004, 'Conflicting ideologies as a source of emotion work in midwifery', *Midwifery*, vol. 20, no. 3, pp. 261-72.
Hunter, B. 2010, 'Mapping the emotional terrain of midwifery: What can we see and what lies ahead?', *International Journal of Work Organisation and Emotion*, vol. 3, pp. 253-69.
Hunter, L.P. 2007, 'A hermeneutic phenomenological analysis of midwives' ways of knowing during childbirth', *Midwifery*, vol. 24, no. 4, pp. 405-15.

International Confederation of Midwives 2011, *Definition of a Midwife*. www.internationalmidwives.org , accessed May 2011, Nov 2012.
Jarvis, P. 1992, 'Reflective practice and nursing', *Nurse Education Today*, vol. 12, pp. 174-81.
Johns, C. 2000, *Becoming a Reflective Practitioner: a refective and holistic approach to clinical nursing, practice development and clinical supervision*, Blackwell Science, Oxford.
Johns, C. 2009, *Becoming A Reflective Practitioner*, 3rd edn, Wiley-Blackwell, Oxford.
Jordan, B. 1993, *Birth in Four Cultures. A Cross-Cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*, 4th edn, Waveland Press Inc, Illinois.
Kandel, E. 2012, *The Age of Insight: the quest to understand the unconscious in art, mind and brain.*, Random House, New York.
Kandel, E., Schwartz, J. & Jessel, T. 2001, *Principles of Neural Science*, McGraw-Hill, New York.
Kennedy, H.P. 2002, 'A model of exemplary midwifery practice: results of a Delphi study.', *Journal of Midwifery and Women's Health*, vol. 45, no. 1, pp. 4-19.
Kennedy, H.P. & Lowe, N.K. 2001, 'Science and midwifery: paradigms and paradoxes.', *Journal of Midwifery and Women's Health*, vol. 46, no. 2, pp. 91-7.
Kennedy, H.P., Rousseau, A.L. & Low, L.K. 2003, 'An exploratory metasynthesis of midwifery practice in the United States', *Midwifery*, vol. 19, no. 3, pp. 203-14.
Kirkham, M. 2000, *The Midwife - Mother Relationship*, Macmillan Press Ltd, London.
Kitzinger, S. 2005, *The Politics of Birth*, Elsevier Butterworth-Heinemann, Edinburgh.
Klassen, P.E. 2001, 'Sacred maternities and postbiomedical bodies: religion and nature in contemporary homebirth', *Signs*, vol. 26, no. 3, pp. 775-810.
Klassen, P.E. 2001, *Blessed Events: Religion and Homebirth in North America*, Princeton University Press, Princeton NJ.
Klein, G. 2003, *The Power of Intuition*, Doubleday, New York.
Koch, T. 1998, 'Story telling: is it really research?', *Journal of Advanced Nursing*, vol. 28, no. 6, pp. 1182-90.
Lane, K. 2006, 'Midwifery a profession in transition', *Australian Journal of Midwifery*, vol. 15, no. 2, pp. 26-31.
Lane, K. 2010, 'When is collaboration not collaboration? When it's militarized.', *Women and Birth*, vol. 25, no. 2, pp. 29-38.
Laszlo, S., Stites, M. & Federmeier, K.D. 2010, 'Task and repetition effects on the semantic processing of items without semantics', *Psychophysiology*, vol. 47, no. Supp 1, p. S28.
Leap, N. 2000, 'The less we do the more we give.', in M. Kirkham (ed.), *The Midwife-Mother Relationship*, Macmillan, Basingstoke.
Leap, N., Barclay, L. & Sheehan, A. 2003, 'Results of the Australian Midwifery Action Project Education Survey - Paper 3. Workforce Issues', *Women and Birth*, vol. 16, no. 3, pp. 12-7.
Leap, N. & Hunter, B. 1993, *The Midwife's Tale: oral history from handywoman to professional midwife.* Scarlet Press, London.
Li, Z.Z.; Hilder,L. & Sullivan, R. 2012, *Australia's mothers and babies 2010.*, vol. Perinatal statistics series no. 27. Cat. no. PER 57. , Government Printers, Canberra.

Lieberman, M.D. 2000, 'Intuition: a social cognitive neuroscience approach', *Psychological Bulletin*, vol. 126, no. 1, pp. 109-37.
Linhares, C. 2005, 'Spirituality in midwifery and childbirth', *Midwifery: pathways to healthy nations. Proceedings of the 27th Congress of the International Confederation of Midwives (CD)*, CMS Australasia (www.cms-australasia.com.au).
Lorde, A. 1984, *Manchild: A black lesbian feminist response*, Sister Outsider, New York.
Luria, A.R. 1973, *The Working Brain, An Introduction to Neuropsychology*, Penguin Books, London.
Maternity Services Review 2009, *Report of the Maternity Services Review*, Commonwealth of Australia, Canberra.
McCormack, B. 1992, 'Intuition: concept analysis and application to curriculum development. Concept analysis. Part 1.' *Journal of Clinical Nursing*, vol. 1, no. 6, pp. 339-44.
McCourt, C. 2005, 'Research and theory for nursing and midwifery: Rethinking the nature of evidence', *Worldviews on evidence-based nursing*, vol. 2, no. 2, pp. 75-83.
McLachlan, H., Forster, D., Davey, M.F., T, Gold, L., Biro, M., Albers, L., Flood, M., Oats, J. & Waldenstrom, U. 2012, 'Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial.' *BJOG*, vol. 119, no. 12, pp. 1483-92.
Meyers, S. 2010, *Contemplating Maternity in an Era of Choice: Exploration in Discourses of Choice*, Lexington Books, London.
Minichello, V., Sullivan, G., Greenwood, K. & Axford, R. 2004, *Research Methods for Nursing and Health Science*, 2 edn, Pearson Education, Sydney, Australia.
Mitford, J. 1993, *The American Way of Birth*, Plume Books, Penguin, USA.
Miyake, N. 1986, 'Constructive Interaction and the Iterative Process of Understanding', *Cognitive Science*, vol. 10, no. 2, pp. 151-77.
Munhall, P.L. 2012, *Nursing Research: A Qualitative Perspective,* 5 edn, Jones and Bartlett Learning, Miami, Florida.
*National Centre for Epidemiology and Research*, Australian National University, 2009, Canberra.
National Health and Medical Research Council 1998, *Review of Services Offered by Midwives*, Australian Government Publishing Services, Canberra.
National Maternity Action Plan (NMAP) 2002, 'National Maternity Action Plan (NMAP),' Australian Government Printers, Canberra.
National Perinatal Epidemiological and Statistics Unit 2011, Australian Government Printers, University NSW, Sydney, Australia.
Nicholls, L. 2006, 'What makes a good midwife? An integrative review of methodologically - diverse research', *Journal of Advanced Nursing*, vol. 56, no. 4, pp. 414-29.
NSW Health Department: Maternity Services in New South Wales 1989, *Final Report of the Ministerial Taskforce on Obstetric Services in NSW (Shearman Report)*, NSW Department of Health, Sydney.
O'Reilly, A. 2004, *Toni Morrison and Motherhood: A Politics of the Heart*, State University of New York, New York.
Oakley, A. 1980, *Women Confined: Towards a Sociology of Childbirth*, Scocken, New York.
Oakley, A. 1989, 'Who cares for women? Science versus love in nurse midwifery today.', *Midwives Chronicle and Nursing Notes*, vol. 102, pp. 214-21.

Oakley, A. 1992, *Social Support and Motherhood: The Natural History of a Research Project*, Blackwell, Oxford.
Odent, M. 2001, *The Scientification of Love*, Free Association Books Ltd., London.
Odent, M. 2011, *Childbirth in the Age of Plastics*, Pinter and Martin Ltd, London.
Odent, M. 2013, *Childbirth and the Future of Homo Sapiens*, Pinter and Martin Ltd, London.
Olafsdottir, O.A. 2011, 'An Icelandic Midwifery Saga Coming to Light "With woman" and connective ways of knowing', University of West London, UK.
Olesen, V. 1993, 'Handbook of Qualitative Research', in N.K. Denzin & Y.S. Lincoln (eds) Sage Publications, pp. 158-74.
Opie, A. 1992, 'Qualitative research approriation of the 'other' and empowerment', *Feminist Review*, vol. 40, no. Spring, pp. 52-69.
Page, L.A. 2004, 'Working with women in childbirth', PhD publication, University of Technology, Sydney.
Parratt, J.A. & Fahy, K.M. 2008, 'Including the non-rational is sensible midwifery', *Women and Birth*, vol. 21, no. 1, pp. 37-42.
Patrick, D. 2002, 'The midwives and mothers intuition in labour study: is instinct extinct on the 21st Century delivery suite?', Unpublished Masters Dissertation, University of Nottingham, England.
Pert, C. 1997, *Molecules of Emotion: the science behind mind-body medicine*, Scribner, New York.
Petitmengin-Peugeot, C. 1999, 'The View From Within: First Person Approaches to the Study of Consciousness', in Varela, J. (ed.) Imprint Academic, London, pp. 43-77.
Phillips, N. & Hardy, C. 2002, *Qualitative Analysis: Practice and Innovation*, Allen & Unwin, Sydney.
Pink, D.H. 2006, *A Whole New Mind: Why Right Brainers Will Rule the World*, Penguin Books Ltd, London.
Pink, D.H. 2009, *Drive: The Surprising Truth About What Motivates Us*, Riverhead Hardcover, New York.
Pinker, S. 1997, *How the Mind Works*, Norton Books, New York.
Polanyi, M. 1966, *The Tacit Dimension*, University of Chicago, Chicago.
Popper, K. 1959, *The Logic of Scientific Discovery*, Springer Publishers, New York.
Ramachandran, V.S. 2011, *The tell-tale brain: unlocking the mystery of human nature*, Heinemann, London.
Reed, R. 2013, 'Midwifery practice during birth: rites of passage and rites of protection', PhD publication, University of Sunshine Coast, QLD.
Reibel, T., Vernon, B., Tracy, S., Key, B., Leap, N., Nixon, A., Robinson, J., Johnston, J., Parratt, J. & Donnellan-Fernandez, R. 2002, 'Maternity Action Plan for the introduction of community midwifery services in urban and regional Australia', *Birth Matters*, vol. 6, no. 3.
Rew, L. 2000, 'Reflection: consulting the truth within', in B.M. Dossey, L. Keegan & C. Guizzetta (eds), *Holistic Nursing Handbook for Practice*, Aspen, Philadelphia.
Rew, L. 2001, 'Acknowledging intuition in clinical decision making', *Journal of Holistic Nursing*, vol. 18, pp. 94-108.
Rew, L. & Barrow, E.M. 2007, 'State of the science: intuition in nursing, a generation of studying the phenomenon.', *Advances in Nursing Science*, vol. 30, no. 1, pp. E15-E25.

Robson, C. 1993, *Real World Research: A Resource for Social Scientists and Practitioner Researchers*, Blackwell Publishers, Oxford.
Rutherford, M. & Gallo-Cruz, S. 2008, 'Selling the ideal birth: rationalisation and re-enchantment in the marketing of maternity care', *Patients, Consumers and Civil Society Advances in Medical Sociology*, vol. 10.
Sandall, J., Devane, D., Soltani, H. & Gates, S., Hatem, M., 2009, 'Discussion of findings from a Cochrane review of midwife-led versus other models of care for childbearing women: continuity, normality and safety', *Midwifery*, vol. 25, no. 1, pp. 8-13.
Sandall, J.D.; Soltani, H.; Hatem,M.; Gates,S. 2010, 'Improving Quality and Safety in Maternity Care: The Contribution of Midwife-Led Care', *Journal of Midwifery and Women's Health*, vol. 55, no. 3, pp. 255-61.
Sandelowski, M. 2000, 'Focus on research methods. Whatever happened to qualitative description?', *Research in Nursing and Health*, vol. 23, pp. 234-340.
Sandelowski, M. 2004, 'Using qualitative research', *Qualitative Health Research*, vol. 14, no. 10, pp. 366-86.
Sandelowski, M. 2007, *Handbook for Synthesising Qualitative Research*, Springer Publishing Co. Inc., Manhattan, New York.
Savin-Baden, M.a.F., A. 2002, 'Negotiating honesties in the research process', *British Journal of Occupational Therapy*, vol. 65, no. 4, pp. 191-3.
Schneider, Z., Whitehead, D., Elliott, D., Lobiondo-Wood, G. & Haber, J. 2007, *Nursing and Midwifery Research: methods and appraisal for evidence-based practice*, 3 edn, Mosby Elsevier, Melbourne.
Shapiro, S.S. & Spence, M.T. 1997, 'Managerial Intuition: A conceptual and operational framework', *Business Horizons*, vol. 40, no. 1, pp. 63-8.
Shuval & Gross 2008, 'Midwives practice CAM; Feminism in the delivery room', *Journal of Evidence Based Complementary and Alternative Medicine*, vol. 13, no. 1, p. 46.
Siddiqui, J. 1994, 'Practice issues: The therapeutic relationship in midwifery', *British Journal of Midwifery*, vol. 2, no. 9, pp. 419-22.
Siddiqui, J. 1999, 'The therapeutic relationship in midwifery', *British Journal of Midwifery*, vol. 7, no. 2, pp. 111-4.
Silverman, D. 1997, *Qualitative Research: Theory, Method and Practice.*, Sage Publications, London.
Silverman, D. 2006, *Interpreting Qualitative Data: Methods for Analyzing Talk, Text and Interaction*, 3 edn, Sage Publications, London.
Silverman, D. 2010, *Doing Qualitative Research*, Third Edition edn, Sage Publications, London.
Smith, A. 2007, 'Measuring the use of intuition by registered nurses in clinical practice', *Nursing Standard*, vol. 21, no. 47, pp. 35-41.
Smith, A., Thuurkettle, M. & Dela Cruz, F. 2004, 'Use of intuition by nursing students: instrument development and testing', *Journal of Advanced Nursing*, vol. 47, no. 6, pp. 614-22.
Smith, D., E. 1987, 'The everyday world as problematic, a feminist sociology', *Gender and Society*, vol. 11, no. 4, pp. 391-408.
Steen, M. & Roberts, T. 2011, *The Handbook of Midwifery Research*, Wiley-Blackwell, West Sussex, UK.
Tandon, R. 1989, 'Three approaches to participative inquiry', in N.K. Denzin & Y.S. Lincoln (eds), *Handbook of Qualitative Research*, Sage, USA: Thousand Oaks, pp. 324-39.

Teijlingen, E.R. 2004, *Midwifery and the Medicalisation of Childbirth: comparative perspectives.*, Nova Science Publishers, Inc., New York.
Thompson, F. 2004, *Mothers and Midwives: The Ethical Journey*, Books For Midwives, Elsevier, London.
Tracy, S. 2006, 'Risk theoretical or actual?', in L.A. Page & R. McCandlish (eds), *The New Midwifery: Science and sensitivity in practice*, 2 edn, Churchill Livingstone, Edinburgh, pp. 227-51.
Trevathan, W. 1987, *Human Birth: An Evolutionary Perspective*, Aldine de Gruyter, New York.
Trevathan, W., Smith, E.O. & McKenna, J. 1999, 'Evolutionary Obstetrics', *Evolutionary Medicine*, Oxford University Press, New York.
Ulrich, L.T. 1990, *A Midwife's Tale: The Life of Martha Ballard Based on Her Diary 1785-1812*, First Vintage Books Edition, New York.
Uvnas Moberg, K. 2003, *The Oxytocin Factor*, Pinter and Martin Ltd, London.
Van Maanen, J. 1988, *Tales of the Field: On Writing Ethnography*, University of Chicago Press, Chicago.
Van Maanen, M. 1990, *Researching Lived Experience*, SUNY press, Alberta, Canada.
Vernon, D. 2005, *Having a Great Birth in Australia*, Australian College of Midwives, Canberra.
Vincent-Priya, J. 1991, *Birth Without Doctors. Conversations with Traditional Midwives*, Earthscan Publications Ltd, London.
Walliman, N. 2011, *Research Methods: The Basics*, Routledge, London.
Wengraf, T. 2001, *Qualitative Research Interviewing: semi-structured, biographical and narrative methods.*, Thousand Oaks,Sage Publications, London, California.
White, R. 2004, *Working with Spirit Guides: how to meet, communicate with and be protected by your guide.*, Piatkus, London.
Wickham, S. 2004, 'Feminism and Ways of Knowing', in M. Stewart (ed.), *Pregnancy, Birth and Maternity Care*, Books for Midwives, Edinburgh, pp. 157-68.
Wickham, S. 2008, *Midwifery: Best Practice Volume 5*, Books for Midwives, Edinburgh.
Williams, R.B. 2002, *Multiple Intelligences for Differentiated Learning*, Corwin Publishers, Thousand Oaks, California..
Winter, C. 2002, 'The progress of labour: orderly chaos? How do independent midwives assess the progress of labour?', University of Dundee, Dundee.
Wolf, N. 1993, *Fire With Fire: The new female power and how it will change the 21st century*, Random House, New York.

# APPENDICES

## APPENDIX 1: Formal email confirmation of ethics approval for this study

**From:** Ethics Secretariat <Research.Ethics@uts.edu.au>

**Sent:** Friday, 21 December 2012 5:28 PM

**To:** Caroline Homer

**Cc:** Fiona Reid; Research Ethics

**Subject:** Eth: HREC Approval Letter - UTS HREC 2012-393A

Dear Caroline and Fiona,

Thank you for your response to the Committee's comments for your project titled, "From Alchemy to Epistemology: Intuition and Private Midwifery in Australia". Your response satisfactorily addresses the concerns and questions raised by the Committee, and I am pleased to inform you that ethics approval is now granted.

Your approval number is UTS HREC REF NO. 2012-393A

You should consider this your official letter of approval. If you require a hardcopy please contact the Research Ethics Officer (Research.Ethics@uts.edu.au).

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in

particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9772.

Yours sincerely,

Professor Marion Haas

Chairperson

UTS Human Research Ethics Committee

C/- Research & Innovation Office

University of Technology, Sydney

Level 14, Tower Building

Broadway NSW 2007

Ph: 02 9514 9772

Fax: 02 9514 1244

Web: http://www.research.uts.edu.au/policies/restricted/ethics.htm

# APPENDIX 2: Magazine Advertisement in Australian Private Midwives Association Magazine

Alchemy to epistemology: Intuition and the Privately Practising Midwife

Privately Practising Midwives are invited to participate in a university research study about their use of intuition.

Are you:

- A Private Midwife
- Willing to be interviewed about your use of intuition
- Currently registered with AHPRA
- Have been practising for more than 3 years
- Have more than 5 clients a year
- No more than 3 years since you attended a birth
- Male or female
- English speaking
- Living within 100 kms of Sydney

You will:

- Be interviewed in your own home/ place of work
- Not incur any costs
- Be helping us to gain a greater understanding of an important and unique aspect of midwifery practise.

All details relating to the interview material will be kept strictly anonymous. If you are willing to participate, please contact Fiona Reid at: (email supplied) Thank you.

# APPENDIX 3: Magazine advertisement in Homebirth Access Sydney

Privately Practising Midwives are invited to participate in a university research study about the use of intuition in their professional practice.

My name is Fiona Reid and I am doing a Master of Midwifery Research (Honours) study on private midwives use of **intuition** in their practise. If you are: a private midwife currently registered with AHPRA, have been practising for more than 3 years, have more than 5 clients a year and have attended births within the last 3 years you are cordially and enthusiastically invited to give me an hour of your time for an interview about your use and understanding of **Intuition.**

All details relating to the interview material will be kept strictly anonymous.

If you are willing to participate, please contact

Fiona Reid at: (email supplied) Thank you.

# APPENDIX 4: Introductory Letter to Midwives participating in the research study

The title of my research study is:

"From Alchemy to Epistemology: Intuition and Private Midwifery in Australia."

UTS HREC Approval Number:

Dear Colleague;

WHO IS DOING THE RESEARCH?

My name is Fiona Reid and I am a Masters of Midwifery (Research) student at UTS. (My primary supervisor is Professor Caroline Homer and my secondary Supervisor is Christine Catling)

WHAT IS THIS RESEARCH ABOUT?

This research is to find out about privately practising midwives use of intuition in their practice of midwifery. The study is interested in whether the privately practising midwives are using intuition and if so, how?

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to let me interview you for one to one and a half hours while we talk about your midwifery experience and use of intuition in your practice. The interview will be audio recorded using a digital recorder.

ARE THERE ANY RISKS/INCONVENIENCE?

The interview will require you to give of your time. I will hold the interview at a location (perhaps your rooms or home) that is convenient for you in order to minimise inconvenience.

Whilst any physical or psychological risk involved is anticipated to be negligible I recognise that we will be talking about your midwifery practice and experiences and that at all times these discussions may result in strong feelings and occasionally, distress. Should this occur I

will stop the interview either temporarily or permanently and will discuss with you how you want to proceed. (I will have the names and contact details of counsellors should you want them)

WHY HAVE I BEEN ASKED?

I am interested in the perspectives of private practising midwives and you have been identified as being in this role currently or in the past XX years.

DO I HAVE TO SAY YES?

You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

HOW WILL THE FINDINGS BE USED?

The research data gathered from this project may be published in a form that does not identify you in any way. It will contribute to a broader understanding of private practising midwives use of intuition in an Australian context.

WILL I BE ABLE TO BE IDENTIFIED?

All the information on the recorded interview and any written communication will be de-identified on all data collected and transcribed during the research study. All information will remain confidential.

HOW WILL YOU PROTECT MY CONFIDENTIALITY?

All data will be de-identified at transcription. Your privacy and confidentiality will be respected at all stages of the research. The Privacy Principles Act of 1998 will be adhered to.

WHAT WILL HAPPEN TO MY DATA?

The data collected during the study will be securely stored at UTS and the written data and audio recordings will be stored separately for a period of seven years.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisors can help you with, please feel free to contact me (us) on:

All aspects of the study, including results, will be kept strictly confidential. A report on the study may be submitted for publication, but individual participants will not be identified in such a report.

Fiona Reid (Phone number supplied. Email supplied)

Professor (Caroline Homer (UTS) Phone number supplied. Email supplied)

Christine Catling (UTS) (Phone number supplied. Email supplied)

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on (02) 9514 9772, and quote this number: *2012-393A (UTS HREC Approval Number)*

# APPENDIX 5: Consent form used with all participants of this study

CONSENT FORM

I _____ (participant's name) agree to participate in the research project 'From Alchemy to Epistemology: are Australian privately practising midwives using intuition in their practice?' UTS HREC Number.(HREC 2012 393-A) Being conducted by Fiona Reid mob: 0438651656 of the University of Technology, Sydney for her degree Master of Midwifery by Research. The project is being supervised by Professor Caroline Homer and Christine Catling at UTS.

I understand that the purpose of this study is to explore if and how private midwives use intuition whilst working with women during childbirth.

I understand that I have been asked to participate in this research because of my relevant expertise and that my participation in this research will involve limited telephone communication with Fiona Reid and attendance at an interview with her that will take one to one and a half hours and will be digitally recorded. All the information on the recorded interview and any written communication will be de-identified on all data collected and transcribed during the research study.

The data collected during the study will be securely stored at UTS and the written data and audio recordings will be stored separately.

Whilst any physical or psychological risk involved is anticipated to be negligible we recognise that you will be asked questions about your midwifery practice and experiences

and that at all times these discussions may result in strong feelings and occasionally, distress. Should this occur the researcher will stop the interview either temporarily or permanently and will discuss with me how I want to proceed. The researcher will have the names and contact details of counsellors should this be necessary.

The interviews will be conducted at a time and place convenient to me to reduce any inconvenience.

I am aware that I can contact Fiona Reid (phone number supplied email supplied) or her supervisor(s) Professor Caroline Homer (UTS phone number supplied) email supplied or Christine Catling (UTS phone number supplied email supplied) if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Fiona Reid has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____

Signature (participant)

_____ ____/____/____

Signature (researcher or delegate)

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

# APPENDIX 6: Demographic information pro-forma used with participants

DEMOGRAPHIC INFORMATION

Collected for the research study by UTS student Fiona Reid: **"From Alchemy to Epistemology: Intuition and Private Midwifery in Australia."** **(**UTS HREC Approval Number: 2012-393A)

This data is anonymous and collected only for the purposes of background information for the study you are participating in.

Gender:

Age:

Education (Nursing, Midwifery, Tertiary):

Type of Midwifery education:

Where did you study midwifery (country, rural, metropolitan):

Year completed:

How many years have you been in private practice?

Which countries or areas of Australia have you have practised in?

What type of practice do you have?

Solo

Group

Shared with one other

On average, how many women do you attend a year?

Do you have a collaborative arrangement with a health service?

Yes

No

In progress

Are you an Endorsed Eligible midwife?

Yes

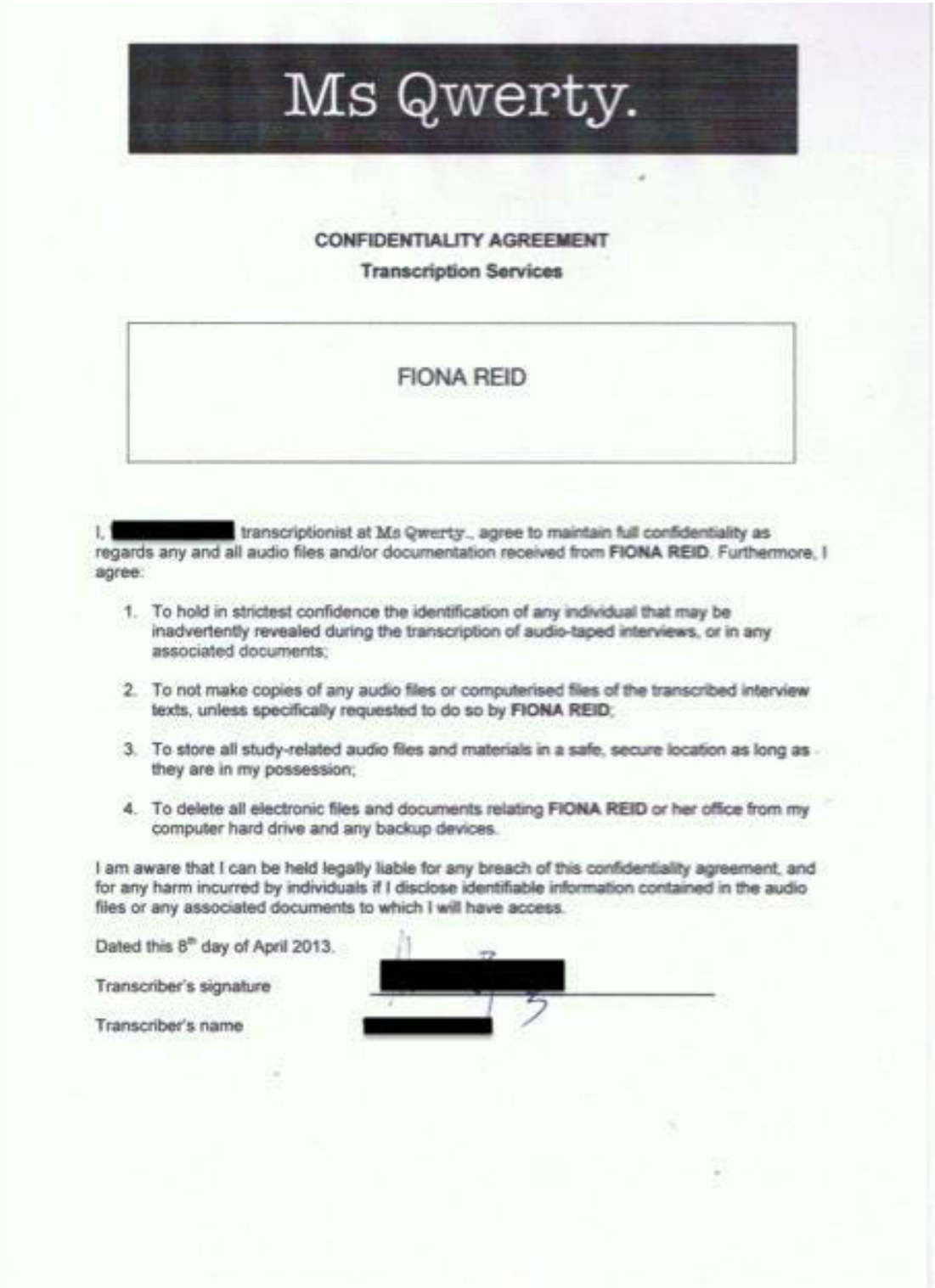
No – but I plan to be one

No – I do not plan to be one

Application submitted and awaiting process

Thank you

## APPENDIX 7: Confidentiality Agreement with transcription service



Ms Qwerty.

**CONFIDENTIALITY AGREEMENT**

**Transcription Services**

FIONA REID

I, [redacted] transcriptionist at Ms Qwerty., agree to maintain full confidentiality as regards any and all audio files and/or documentation received from **FIONA REID**. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;
2. To not make copies of any audio files or computerised files of the transcribed interview texts, unless specifically requested to do so by **FIONA REID**;
3. To store all study-related audio files and materials in a safe, secure location as long as they are in my possession;
4. To delete all electronic files and documents relating **FIONA REID** or her office from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio files or any associated documents to which I will have access.

Dated this 8th day of April 2013.

Transcriber's signature [redacted]

Transcriber's name [redacted]