The Moral Compass: Women’s Experiences of Excellent Midwives

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Abstract

For midwifery practitioners, the concept of excellence is central to the ethos of quality midwifery care (DH 2009, NMC 2009) and although midwives are being asked to aspire to ‘a standard of excellence’ (DH 2009), the meaning of ‘excellence’ for both women and midwifery practitioners has not been defined. The focus of this study is to understand excellence at a personal level, what makes some midwives ‘stand out’ and what it means to ‘be’ an excellent midwife, from the service users perspective.

This thesis explores the meaning of an excellent midwife through twelve women’s lived experience of midwives and midwifery care, using a hermeneutic phenomenological approach in the Heideggerian-Gadamerian tradition. Data were generated using email-facilitated group discussion which focused on the women’s understanding of the meaning of an excellent midwife.

Data were analysed in the style of Van Manen,(1990) and reveal three specific dimensions of midwifery excellence – the person themselves (moral being), professional knowledge (authentic professionalism) and caring actions (relational care), also conceptualised as ways of being, knowing and showing.

The findings suggest that excellence is an intrinsic part of the individual themselves; a quality of moral character that the midwife brings to midwifery and which forms a foundation on which midwifery excellence is built. The conceptual metaphor of a ‘moral compass’ is used to describe the way in which the midwife blends her ways of being, knowing and showing to ‘be’ excellent. In this way, excellent midwives are understood as excellent individuals who bring excellence in ‘being’ to their professional role.
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Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed:

Dated:
Introduction

1.1 Excellent midwives – what makes them excellent

Women’s experiences during maternity care have been of growing interest in the United Kingdom (UK) in the last thirty or so years, starting with sociological studies like those by Oakley (1979, 1980, 1993), Government reports (House of Commons Health Select Committee 1992, DH Expert Maternity Group 1993, DH 2007) and most recently, initiatives like the National Service Framework (DH 2004). There have also been a number of large scale user surveys such as ‘First Class Delivery’ (Audit Commission 1997), ‘Recorded Delivery’ (Redshaw et al. 2007), ‘Towards Better Births’ (HCC 2008) and most recently ‘Delivered with Care’ (Redshaw and Heikkila 2010). However, while these all aim to improve maternity services and the care that women receive, the main focus has been predominantly maternity services as a whole, rather than the individual midwives who work within them.

The experience of pregnancy and birth constitutes an important and long remembered part of many women’s lives, which may have long term consequences for how women adapt to motherhood. At an individual level, midwives can have a significant impact on a woman’s experience of pregnancy, birth and early motherhood and this is already well documented within the professional discourse (Berg et al. 1996, Kirkham 2000, Kennedy 2002, Pembroke and Pembroke 2008). However, although some elements of midwifery care, such as the midwife-woman relationship (Fleming 1998, Pairman 2000, Freeman, Timperley and Adair 2004, Lundgren and Berg 2007, Hunter 2006a, Hunter et al. 2008, McCourt and Stevens 2009), have received significant focus, thus far there
has been surprisingly little exploration of midwives themselves and more particularly, of the reasons why some are considered to be outstanding, exemplary or excellent.

Some midwives are certainly different, possessing certain qualities, attributes and characteristics that make them ‘stand out’ amongst their peers, however, while these midwives are often easy to identify, understanding why they are considered excellent or outstanding, and what makes them excellent would seem to be a much more complex phenomena. Although excellent or outstanding practitioners are frequently described as possessing ‘it’ (Kendall 1999), what ‘it’ consists of would appear to be a somewhat nebulous concept, thus far defying a definitive description. Therefore, this research study seeks to uncover what it is that makes some midwives stand out amongst their peers, such that they can be described as ‘outstanding’ or ‘excellent’ (Pollard and Liebeck 1994).

The beginnings of this study are grounded firmly in my own perspectives of midwifery practice and in my journey to discover what it means to be excellent in the context of being a midwife. My own understanding has been shaped by many factors within my past life history and personality, but most immediately through my experiences and observations over many years as a midwife and more latterly, as a midwife involved in supervising and educating students of midwifery and supporting the development of other midwives within a practice development role. I found myself trying to understand what exactly quantified ‘excellent’ and wondering if it would be possible to make all midwives ‘excellent’ through application of those elements considered essential to its definition. This is where the study began, and where my early attempts to uncover the essential components of excellence, are grounded.
Therefore, the following discussion considers what is already known regarding midwifery excellence with the aim of understanding how this relates to midwives as individuals. Although there is no requirement for midwives to be women, most midwives like other ‘care’ professions, are still predominantly women and for this reason midwives are referred to throughout this study using a feminine prefix when required. This is simply for ease of use and it should be noted that although midwives are referred to as ‘she’ the intention is to include all midwives.
Current understanding of midwifery excellence

2.1 Introduction

For midwives, the concept of excellence is linked to the ethos of quality midwifery care as noted within the NMC (2009) standards for pre-registration midwifery education, and the most recent Department of Health document ‘Delivering high quality midwifery care: the priorities, opportunities and challenges for midwives’ (DH 2009),

“The quality of midwifery care in the NHS must reach the world class standards of excellence to which the profession aspires and which women and their families expect from our service” (DH 2009:9)

While this suggests that women expect excellence and it is something to which the profession should aspire, there is currently little consensus as to what defines excellent practice, excellent care or excellent midwives. Therefore, this could be seen to represent a significant problem for the service, the profession and for individual midwives in their aspiration to achieve excellence and to provide the kind of quality care that women and their families expect.

Standards do exist for defining the level required for midwives’ basic competence at qualification, both in the UK (NMC 2004, NMC 2009) and worldwide (ICM 2002, Fullerton and Thompson 2005) and while there is an expectation that midwives, like other healthcare professionals, maintain, develop and advance their practice
(NMC 2008), there is currently no definitive standard of ‘how’ midwives might achieve this and exactly ‘what’ they need to achieve. Moreover, although midwives are being asked to aspire to ‘a standard of excellence’ (DH 2009) what that means for women, and for midwives, is rather unclear.

Although there would appear to be a general understanding of excellence, within healthcare at least, as synonymous with the expectation of best quality care and optimum practice (Henderson 1998, Carthey et al. 2003, Charalambous, Papadopoulos and Beadsmoore 2009, DH 2009), there would seem to be a degree of uncertainty about how it should be measured and what standards or criteria should be used by which to decide if excellence has been achieved. Furthermore, as Rolfe (2003) suggests, in the NHS the criteria used to judge excellence may vary considerably and be dependant on the dominant ideologies of the time, such that excellence in healthcare services may come to be judged in terms of management and administration criteria rather than those of patient experience, quality and wellbeing outcomes.

Readings (1997) considers that these problems occur because excellence as a descriptor is non-ideological, that is it is ‘not a fixed standard of judgement but a qualifier whose meaning is fixed in relation to something else’ (Readings 1997:24) and it is this which means that it can function as a ‘principle of translatability’ (Readings 1997:27) amongst radically diverse idioms. Therefore, the use of excellence, without reference to the contextual position in which it is to be understood, provides only a very general conceptual understanding of what it represents, hence the apparent difficulty of knowing what it really means, particularly in relation to individual practitioners.
Therefore, this discussion will consider the current professional discourses within this field in an attempt to contextualise the meaning of excellence with regard to midwives and midwifery care. While there would appear to be many features which contribute to this apparent confusion and the difficulties of understanding excellence, particularly in relation to what it means for midwives as individuals, they might be considered as relating to:

- language and the multiplicity of meaning

- the influence of perspective and context

- the focus of meaning

The following explores the concept of excellence, within the framework of these three positions, to consider how excellence may be understood at the present time and to shed further light on the topic.

2.2 Literature search strategy and methods

An initial search was conducted of the abstracts, titles and text held within multiple databases including Medline/PubMed, NMAP, CINHAL, Biome and BNI using the keywords ‘excellen*’, ‘exemplary’ and ‘midwi*’ or ‘nurse-midwi*’. The search was limited to studies published in English and initially to a date range of 1995 to the present time. At the time of the project start in early 2005, this represented studies published within the previous ten years and this has necessarily been extended
and updated to include new studies published since 2005 and other literature of relevance.

Following the initial searches it became apparent that there was a dearth of literature discussing the concept of excellence, and when studies which did not relate specifically to practice or practitioners themselves were removed, only a few remained. Therefore, the search parameters were widened to include all health professions - ‘nurs*’, ‘doctor’ or ‘clinician’, and to consider other words that might be used alongside or interchangeably with excellent such as ‘good’, ‘best’, ‘quality’, ‘expert*’ and ‘ideal’. Those found were read and grouped for significance and ‘fit’ within the initial search parameters – a focus on the individual practitioner. The search was further concentrated by follow up of research papers, government documents and other publications, mentioned within these relevant papers.

Although this approach revealed a larger number of potentially relevant papers, deeper reading and grouping by relevance, resulted in selection of thirteen papers which were considered to focus on practitioners at an individual level. Of these, seven were specific to midwives, two to doctors and four to nurses. Although none of these studies mentioned the word ‘excellent’ specifically, they alluded to the concept generally, utilizing a range of terminology and including excellent within their search strategies and were therefore felt to be associated with excellence. All were concerned with the individual practitioner, at least in part, and this will be discussed and highlighted further within the following discussions. Several other studies mentioned desirable attributes or qualities but were not specifically focused on the individual and these will be also be discussed and the reasons for their exclusion explored within the following discussions.
2.3 Language and the Multiplicity of Meaning

Although excellence is a common enough descriptor within everyday language and represents a general understanding of it as meaning above the average, extremely good or of great merit or quality (Pollard and Liebeck 1994), there would seem to be some confusion associated with its use, particularly in the field of healthcare. In the United Kingdom (UK) for example, medical practitioners are ‘Aspiring to Excellence’ (Tooke 2008), the National Health Service (NHS) is ‘Striving for Excellence’ (DH 2010) and the National Institute for Health and Clinical Excellence (NICE) is producing guidelines for excellent clinical practice. In addition, excellence may be applied to services as a whole, to practitioners, in groups or as individuals, and can be achieved through evidence-based practice (Affonso 2003, Sleep, Page and Tamblin 2002), accountability (Millenson 1999), continuing professional development and quality assurance (Morales, Maliszewski and Greenlees 1995, NMC 2008).

Excellence as a concept has been linked with many words, such as caring (Hegedus 1999, Scott 2000), wisdom (Baltes and Staudinger 2000), empowerment (Raatikainen 1997) and competence (Worth-Butler, Murphy and Fraser 1995, Butler, Fraser and Murphy 2008) but would seem to be most frequently associated with ‘good’ (Hicks 1995, Tonks 2002, Duncan, Cribb and Stephenson 2003, Nicholls and Webb 2006, Rush and Cook 2006, Brady 2009, Byrom and Downe 2010) and ‘expert’ (Benner 1984, Downe, Simpson and Trafford 2007). A few have used other words, like Kendall (1999) who used the word ‘star’ to define the attributes of outstanding oncology nurses, Reiger and Lane (2009) who used ‘ideal’ in their study of nurses and Kennedy (2000) who used the term ‘exemplary’ in her study of midwives. Although the range of
language used is diverse, these studies might all be trying to achieve the same goal, that is, of identifying and describing the attributes required of practitioners considered to be outstanding or excellent.

However, although when asked, peers are easily able to identify those amongst their colleagues whom they consider to be ‘excellent’ (MacLeod 1996, Kendall 1999, Sonnentag 2000, Bonner 2003) and patients are also able to nominate those whom they consider excellent (Nursing Standard 2008), there is generally much greater difficulty in defining the specific attributes that make these individuals different from other practitioners. In these studies, multiple different qualities representing features of excellence are identified. In addition, the words used as descriptors are also very varied, with many different words being used concurrently within the same paper. For example, Downe and colleagues (2007) use the words ‘exemplary’, ‘excellent’ and ‘experienced’ interchangeably with ‘expert’, and would also seem to see these words as consistent with the term ‘beyond the ordinary’ (Downe, Simpson and Trafford 2007:128). While Nicholls and Webb (2006), in their review of the literature on the meaning of a ‘good’ midwife, seem to consider Kennedy’s (2000) use of the word ‘exemplary’ to be analogous with ‘good’. This highlights the complexity of discerning meaning across divergent studies.

Moreover, the current dearth of literature within healthcare using excellent or excellence as the feature descriptor when exploring outstanding practitioners, may only relate to a difference in understanding. In light of this, it would seem worthwhile to start by considering the meaning ascribed to these words and to understand how they may relate to the concept of excellence.
2.3.1 *Experts and ‘Stars’*

Excellence would seem to be commonly associated with expertise (Downe et al. 2007) and, indeed, the two seem to have become inextricably linked, possibly as a result of Patricia Benner’s seminal work ‘From Novice to Expert: Excellence and Power in Clinical Nursing Practice’ (1984). Within this developmental model, expertise is seen as the highest level of practice achievement (Coulon et al. 2004) and might therefore be considered synonymous with an understanding of excellence as the optimum in practice. The features used by Benner to describe excellent practice are such that they may only be achieved by experienced ‘experts’ and therefore it would not be unreasonable to suggest a link between expert status and excellent practice/practitioners.

Therefore, if excellence is to be defined in this way, in terms of optimum all round performance, then expert practitioners are the most likely to evidence this kind of care. Indeed, because as many as eighteen key characteristics of optimum practice have been suggested (Butterworth and Bishop 1995) it would be difficult for any but the most experienced of practitioners to achieve all of these. In this view of excellence, the premise is that experts give excellent care (Fulbrook 1998, Kendall 1999) and therefore a level of expertise is pre-requisite for this. Within midwifery, this view seems to be supported by Downe and others (2007) as shown in their meta-synthesis of the concept of expert midwifery practice, where the words expert and excellence are linked in their exploration of optimum practice in midwifery.

Consequently, if excellence is associated with a level of practice like expertise (Benner 1984, Benner and Wrubel 1989) this would suggest that excellence may
be being viewed as an outcome of expert practice; expert practice produces care which is considered excellent. However, although those described as excellent are usually considered to be experts, excellence has also been described amongst those considered competent but not expert (Kendall 1999). This throws a different light on understanding excellence, perhaps suggesting that excellence may be linked to other features of the practitioner themselves and may therefore be independent of expertise.

While it is beyond the scope of this discussion to fully explore the nuances of expertise, it is likely that those studies which link expertise and excellence have done so either because attributes they consider representative of excellence are also found amongst experts or because the attributes that they link with excellence are related to the meaning of an expert practitioner. The complexity of understanding excellence arises from knowing which features, if any, are specific to an understanding of excellence rather than expertise. One way to do this may be to consider the features found in studies where expertise was not considered important, such as Kendall’s (1999) study of oncology nurses.

Although Kendall uses the word ‘star’ to represent those nurses who ‘stand out’ (Kendall 1999:113) amongst their peers, there is little doubt that she is talking about a certain quality which these individuals seem to possess and she also links this with the concept of excellence:

“The qualities, behaviour, attitudes and role performance of the ‘star’ nurse are representative of outstanding clinical performance, and could be used as a criteria for defining excellence in clinical practice” (Kendall 1999:122)
However, while she agrees that many of those described as ‘stars’ would fit comfortably within Benner’s (1984) construct of expert practitioners, she does not consider expertise a foundational feature of excellence. Many of the nurses described as ‘stars’ in her study did not have the level of experience in practice traditionally associated with experts and of those who did, the features of ‘star’ quality were considered to be apparent long before they reached this level of practice. Indeed, Kendall (1999) suggests that those with the potential to become ‘star’ nurses could already be identified early in their career development, suggesting something distinctive and identifiable about them as individuals.

Unfortunately, Kendall also notes that the essence of this ‘star’ quality is difficult to identify as it seems to be fused with many other elements of clinical practice, such as professionalism, knowledge, commitment, caring and the ability to develop meaningful relationships. However, she does suggest that what might make these nurses different to their peers is a feature integral to their own being – how they feel about themselves and thus how they are able to positively affect the feelings of others around them.

At first sight therefore, this leaves us with two perspectives on expertise and excellence - excellence as an outcome of expert practice and excellence as a feature of the individual themselves. Although practitioners who have reached the highest levels of practice may also be described as excellent, this could be seen as a result of features specific to the individual themselves which provided the personal motivation that encouraged them towards becoming expert practitioners. Such a predisposition towards excellence might then be seen as characteristic of the individual, rather than as a product of expertise, and this would also explain why those not considered experts may also be described as excellent.
2.3.2 Good, Exemplary and Ideal

While many studies seem to link excellence with expertise, there are also a significant number of published studies that consider what it means to be a ‘good’ nurse (Fealy 2004, Radwin et al. 2005, Bjorkstrom, Johansson and Athlin 2006, Rush and Cook 2006, Brady 2009), midwife (Nicholls and Webb 2006, Byrom and Downe 2010, Carolan 2010) or doctor (Duncan et al. 2003) and the word good, alongside those such as exemplary (Kennedy 2000) or ideal (Reiger and Lane 2009) are frequently used in descriptions of healthcare practitioners.

On a basic level, good has a number of meanings, any of which might be relevant to descriptions of outstanding nurses, midwives or doctors. For example, good can be defined as meaning thorough, right, proper, beneficial, virtuous, moral, kindly and well behaved (Pollard and Liebeck 1994). In addition, it can be seen as synonymous with words such as exemplary (Nicholls and Webb 2006) or represent a lower level than excellence within a descriptive continuum (Coulon et al. 2004, Smith and Greaves 2010). In most studies, good is used interchangeably with other concepts and represents a number of meanings, however, in much the same way as ideal or exemplary, good would seem to be associated predominantly with attempts to define the key attributes of those considered to represent excellent or outstanding practitioners.

Perhaps the reason for choosing to use good, ideal or exemplary rather than excellent to describe healthcare practitioners may rely on an understanding of these words at a more conceptual level. For example, ‘good’ may also represent
an underlying understanding of individuals in a moral sense, while ideal and exemplary may suggest practitioners who conform to professional or social conceptions of how a nurse, midwife or doctor should be. Indeed the concept may be so deeply embedded within the social consciousness, Fealy (2004) suggests that the good nurse ideal influences professional identity and this is likely to be similar in midwifery practice.

This makes it difficult to understand what is really meant by the term ‘good’ (Brady 2009) in these studies as much of the understanding may be hidden in underlying assumptions about what it means to be ‘good’ in the social, professional or institutional context. In addition, the concept of good may be understood in the sense of representing a lower level of achievement than excellence. For example, a study by Smith and Greaves (2010) found that 75% of the doctors they interviewed aspired to clinical excellence, which is interesting given that excellence rarely features in the descriptions of outstanding practitioners or of practice. ‘Good’ is a more common descriptor for individuals and this may highlight a perception of excellence as linked with clinical practice as a whole, rather than to the individual doctor, nurse or midwife. However, because good, excellence and expertise are all used interchangeably with little distinction between meanings, exact meaning is difficult to define.

2.4 The influence of perspective and context

As Tonks (2002) suggests the meaning of excellence is largely dependant on the perspective from which it is considered and therefore ‘perspective matters’
(Mander and Fleming 2009:1), therefore it is important to consider the potential influences of differing perspectives. Women using maternity services, midwives, managers, the midwifery ‘profession’ and the wider NHS, represent a wide range of opinions and expectations and while there may be many consistent features, it is likely there will also be some degree of divergence, particularly with regard to what each group considers most important. The following discussion considers some of these concerns as a way of contextualising how these multiple, and sometimes competing perspectives, may influence meaning and contribute to the understanding of individuals, groups and organisations.

2.4.1 Influences on women service users

Since ‘Changing Childbirth’ (DH Expert Maternity Group 1993) in the early 1990’s, a period of more than twenty years, there has been growing interest in understanding what women want from maternity services and more recently there have been several large national surveys of women’s experiences of maternity care (Redshaw et al. 2007, HCC 2008, Redshaw and Heikkila 2010). While there are a number of recommendations which are highlighted within these surveys, one of the most prominent features is a need to make the user perspective more central to any development in services. In conjunction with this, a focus on the needs of individuals is also a central theme within the National Service Framework for Children, Young People and Maternity Services (DH 2004), which states women should:

“have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies” (DH 2004:4)
Despite this, many prominent childbirth activists (Oakley 1980, Kitzinger 2006, Savage 2007) would argue that midwifery services have a long way to go in really listening to women and understanding what they want from maternity care. Indeed, Homer (2006) suggests that although there are numerous studies which highlight women’s experiences and what they want from maternity care, widespread change in maternity services has not yet taken place and therefore, many women remain dissatisfied with their care.

These large scale patient surveys (Redshaw et al. 2007, HCC 2008, Redshaw and Heikkila 2010) do provide some information that may help to understand the perspective of women, however, a number of authors (Avis, Bond and Arthur 1995, Staniszewska and Ahmed 1999, Speight 2005) have expressed concerns about measuring quality in this way. For example, in nursing, O’Connell and others (1999) found that patients were unable to separate nursing care from their overall experience and found it hard to distinguish between multiple carers. This suggests that surveys which are broad and attempt to capture the patient experience of a large number of inter-related topics at the same time, may be unreliable in providing accurate information, as patients are inclined to rate their overall rather than specific experience. In addition, the style and format of questions asked in many surveys might appear to be seeking to validate the current system of care, rather than looking to discover a more individual perspective (Edwards and Titchen 2003).

Other factors which have also been found to impact on patient satisfaction include those such as expectation (Fenwick et al. 2005, Hauck et al. 2007), experience (Atkinson and Medeiros 2009) social, cultural (Larkin, Begley and Devane 2009) and educational background (Lumby 2000). Combined with the powerful influences of gender and care within an institutionalised system (Freeman et al.
2004), these may all exert considerable influence on how women express their experience. Women approach pregnancy and birth from many different starting points and with a variety of expectations and experience (Raphael-Leff 2001) so although childbirth may be something of which many women have experience, each woman’s individual experience is personal, subjective and particular and situated within a cultural framework specific to them (Larkin et al. 2009). This can obviously have a huge impact on understanding what women want and what individuals see as important.

For this reason there has been greater interest in individualised approaches to maternity care which seek to promote women’s informed choice (O’Cathain et al. 2002, Carolan and Hodnett 2007), woman centred care and partnership working (Fleming 2000, Thompson 2003, Freeman 2006, Carolan and Hodnett 2007). However, while the current rhetoric is very much about encouraging women to assume control and make choices that are particular to themselves, some suggest that the reality of care in the NHS is far from this ideal (Madi and Crow 2003, Mander and Melender 2009).

This apparent dichotomy, in which choice is encouraged but is in reality limited to what is considered acceptable to the professional or organisation, results from healthcare professionals beliefs that service users are incapable of understanding the responsibility inherent in true choice (Stanley and Reed 1999). In midwifery, Pollard (2010) reports that midwives often felt women were being unreasonable in challenging medical perceptions of risk. Therefore, while individualised care and informed choice is espoused as a central tenant of midwifery practice, for women, choice may often be limited to what the midwife considers best.
Wider social influences also affect how women voice their expectations and experience which can mean that they struggle to voice their own opinion (Gilligan 1982, Belenky et al. 1986), believing that the midwife or doctor know best (Bluff and Holloway 1994). They may also withhold their own views or opinions, even in circumstances where it is contrary to their own wishes, in order to foster or maintain a good relationship with the midwife or doctor.

Women may also value skills and knowledge associated with the feminine such as caring, communication and intuition over those more commonly associated with the masculine, such as technological skills (Holland 2001). In addition, because women service users already hold considerable belief in professional expertise they are unlikely to question individual practitioner competency (Bluff and Holloway 1994, Fleming 1998, de Raeve 2002). For them, this is taken as a given, and it may be why technical skills are not often mentioned by patients when describing aspects of good and bad care (Schmidt 2003, Morton and Konrad 2009). This is not to say that women do not place value on such skills and competencies, but rather that most service users quantify this measurement according to their own beliefs, experiences and expectations (Ip, Chien and Chan 2003). In addition,

“what patients remember most are the subjective and relational aspects of their encounters with health professionals and not the technical aspects of the care received” (Morton and Konrad 2009:207)

Furthermore the influence exerted by personal experience and expectation is considerable, as van Teijlingen and others (2003) found in their survey of the satisfaction levels of Scottish maternity patients. Women were unable to easily articulate what they wanted and found it equally difficult to express dissatisfaction
with current services, particularly when they were not aware of what else was available. For example, in the van Teijlingen and others (2003) study, some women received care from one midwife practitioner throughout while another group received care from a variety of midwifery practitioners. When later questioned on how important one-to-one care was to them, two thirds of the women who received one-to-one care rated this as very important, whereas, only a quarter of the women who had multiple carers thought one-to-one care important. Although this study is in contrast to many others which suggest that knowing your midwife is important to women (Hodnett 2000, Freeman 2006, Williams et al. 2009), it does show that for these women personal experience was a significant factor in defining what they wanted.

Moreover, achieving a positive birth experience may be entirely dependant on achievement of those expectations which the woman herself sees as a priority (Hauck et al. 2007) and these can vary widely between women. In addition, the quality of support afforded to women during their childbearing experience can be very variable (Berg et al. 1996, Hunter 2004) and this can have a significant impact on women’s experience of birth (Lundgren and Berg 2007). For many women, negative feelings of their birth experience are often related to individual caregivers, rather than to how or where care is given (Fraser 1999) with Kirkham (2000) suggesting that women’s experiences may be wholly dependant on the individual midwives that they encounter.

Additionally, while the majority of medical specialities possess a degree of technical uniformity that characterises practices across national borders, birth practices vary considerably worldwide and are clearly impacted by the social influences of the societies in which they occur (Devries et al. 2001). The context of birth in the UK is complex and evolving however, although women in the UK have
a degree of choice regarding place of birth, the majority of them give birth within the institutional context of the National Health Service. Therefore, while birth may be seen as a social, psychological, physiological and emotional experience, women are also confronted with the dichotomous conceptual positions of birth as a natural and normal life event on one hand and birth as dangerous and potentially pathological on the other.

This tension, between the paradigms of birth as normal or pathological is perhaps a legacy of the large scale movement in the place of birth from home to hospital in the UK during the 1970’s. This was influenced by developments in obstetric practices which classified more pregnancies as high risk and by the recommendations of the Peel Committee (Department of Health and Social Security 1970). Birth was only considered normal in retrospect and women were encouraged to believe that a good outcome could only be guaranteed by the omnipotent presence of the obstetrician who could intervene when things went wrong (Kitzinger 2006).

Although these recommendations, which advocated 100% hospital birth have since been refuted, and women have been encouraged to consider home birth as a safe option (DH 2007), they may still exert considerable influence on women’s decisions today (Edwards 2008). Therefore, because birth may be seen by some women and their families as a risky event (DeJoy 2010), safety is likely to be of paramount importance. Women considering birth from such a pathological perspective are likely to put much higher value on the technological aspects of care, while others, seeing birth as a normal sociological life event may be more inclined to focus on the pyscho-social and emotional side of care.
Moreover, the effects of gender and motherhood are inextricably linked and the way that women see themselves is largely due to influences exerted on them by society as a whole, during their development as women and as they are making the transition through pregnancy and birth to motherhood (Oakley 1979, 1980). In all, this makes understanding what women want from maternity care and from their carer's a complex, multi-faceted and constantly changing phenomenon.

2.4.2 Influences on midwifery and professional perspectives

While the ‘with woman’ philosophy of midwifery remains an abiding concept amongst midwives (Hunter 2002, Page 2003, Parratt and Fahy 2003, Carolan and Hodnett 2007), midwives in the NHS in the UK work predominantly within a dichotomous environment which requires them to balance the ethos of individualised care with the practicalities of caring for large numbers of women (Finlay and Sandall 2009). In addition, whilst midwives are asked to focus on promoting normality in birth (RCM 2008, DH 2009, NMC 2009) seeing birth as a normal physiological event within a psycho-social context, they are also being asked to become increasingly more specialised, academically qualified and technologically skilled (DH 2009). Skills such as caring and support (Kirkham 1999) are promoted and midwives are cautioned of the dangers of being ‘subsumed into techno-rational science’ (Fahy 1998:11) while they are also being warned that the current focus on normality and midwifery led care may lead to an exclusionary model of care for normal women only (Carolan and Hodnett 2007).
Attempting to balance these diverse perspectives, has been recognised as a significant source of emotional stress amongst midwives (Hunter 2004, 2005, Thompson 2005, Blaaka and Schauer 2008) as midwives struggle to reconcile the ‘with woman’ with the ‘techno-rational’. This can result in a polarisation of practice philosophies which may have serious implications, a concern that Pollard (2010) seems to support. Pollard found that many midwives made a clear distinction between midwifery dealing with ‘normal’ women and considered holistic, in contrast to those defined as at higher risk, where care was seen as more compartmentalised. In addition, for some of the hospital based midwives, the skills associated with care of normal women were seen as basic and unchallenging with little scope for them to demonstrate their specialist knowledge.

Therefore, many hospital based midwives placed a much higher value on technological skills than those associated with the support of normal birth (Pollard 2010). In Woodward’s (1997) earlier study, midwives also demonstrated a focus on instrumental caring, influenced by the demands of medicine and practical doing, rather than the expressive caring associated with the personal and emotional aspects of women’s needs. Fahy (1998), Leap (2000), Walsh (2006) and Blaaka and Schauer (2008) all emphasise that the midwives role should be one of ‘being’ rather than simply ‘doing’ however, in everyday NHS practice, there is often much greater value placed in the practical aspects of care.

The practice environment therefore, is frequently linked with the type of practice philosophy that midwives favour and it is suggested that those working in community settings are more likely to favour relational caring (Van Der Hulst 1999) and to derive satisfaction from their relationships with women. Midwives who work predominantly within the community environment or within midwifery led units seem to maintain a focus on those skills associated with the psycho-social elements of the midwifery role - communication, relationship building and support,
with women reporting greatest satisfaction with this approach to care (Walsh 2006).

For midwives working in the hospital context, emotional support is more likely to be derived from their relationships with colleagues rather than women. This may be a feature of the work systems within these different environments, as midwives in hospital usually have limited opportunities to get to know the women for whom they care and to build the kind of meaningful relationships valued by community based midwives. Moreover, midwives working in an institutional context may find that their personal practice philosophy is subject to compromise, because challenging the written and unwritten rules and ‘practice conventions’ (Parsons and Griffths 2007: 32) is difficult, often putting them at odds with their peers, as well as the system as a whole (Kirkham 1999, Stewart 2001). The tensions of these competing ideologies may be most obvious amongst midwives working between environments and amongst newly qualified midwives and students (Hunter 2004, 2005).

In addition, the achievement of professional status within midwifery seems to have taken on increasing importance in recent years, perhaps in an attempt to fulfil the traditional view of what constitutes a profession (Abbott 1988). Midwifery education has already moved to provide for a graduate level qualification and many of the attributes associated with higher status professions are advocated including Masters level qualification, delegation of responsibilities to another occupational group (in this case, midwifery support workers) and greater involvement of midwives in research and academic career pathways (DH 2009).

This might be seen as similar to the educational pathways of more established professions such as medicine and may represent midwifery’s attempts to achieve
professional authentication through the use of traditional, academically validated models of professional practice. Midwifery, along with nursing, teaching and other women-dominated occupations, has been traditionally delineated by lower levels of academic qualification, autonomy and status and long considered a semi-profession (Etzioni 1969). More recently midwifery might be seen to be distancing itself from the low status, apprenticeship style training of earlier times, to an all graduate, higher status profession of midwifery (Paxton 2009).

Although this may be beneficial to midwifery as a profession and perhaps supports midwives attempts to maintain a separate identity, there have been some concerns raised about how this may change the essential nature of midwifery (Carolan and Hodnett 2007). The current motivation towards academic qualification and higher social status may result in a de-valuing of the more traditional elements of midwifery practice (Woodward 1997) such as communication, support and caring (Kirkham 1999) in favour of a more technological focus. As suggested by Downe and others,

“The notion of vocation has fallen from favour as skilled practitioners have pursued the aim of professional credibility. However, in gaining the status of profession, with the consequent super-valuing of higher level education, the qualities and values of vocation may well have become overlooked” (Downe et al 2007:136)

While the midwifery profession is keen to increase its status, perhaps as a way of equalising the power imbalances between obstetric medicine and midwives, an increase in professional power may only result in increasing the gulf between women and midwives (Oakley 1993).
In addition, approaches to care within maternity services in the UK may be varied with many different models of care in use; however, the common element within all care models is still the midwife herself. Although some models of care are credited with providing better quality care with higher levels of satisfaction for both the woman and midwife (Sandall et al. 2010, McCourt and Stevens 2009) it is difficult to know if this is related to the care model itself, to the person of the midwife or a combination of the two. Since it is difficult to separate the midwife from the care equation it is hard to say with any certainty, however, as Kirkham (2000) has suggested, alternative care schemes in and off themselves may not necessarily provide better care for women as they are still largely dependant on the approach to care of the individual midwife themselves. Therefore, it is possible that differences in care and outcome may only be related to the type of midwife whose choice it is to work within these models rather than to the model of care itself.

Midwives in the UK are still predominantly women who have developed within a social environment that has become increasingly influenced by technology and the benefits of modern medicine (Armstrong 2006). They are also socialised into a profession with a long history of dominant patriarchal control by medicine (Donnison 1977, Parker and Gibbs 1998) and this has defined what is of value and what is not and has also limited what midwives can do and know. Many midwives belief in the safety of hospital birth, despite their supposed knowledge of evidence to the contrary, is not really surprising if considered in light of the institutional and sociological influences to which they are exposed. Midwives are under a double influence, one of social beliefs about birthplace and the other of the medical influence within which they have trained and become institutionalised (Parsons and Griffiths 2007).

An additional tension results from the way in which financial efficiency and measurement of outcomes has been linked to measurable outcomes such as
mortality rather than the softer and more difficult to measure emotional and social aspects of care. In recent years it has been suggested that changes now recognise the importance of taking into account the emotional as well as physical aspects of care (Wrede, Benoit and Sandall 2001). While it is undoubtedly true that there is more of a focus on the patient perspective, there is still a significant emphasis within maternity care in the UK on institutionally driven goals which may often conflict with the more socio-emotional care valued by women and midwives.

In addition, healthcare is still seen as both a business as well as a service for human beings (Laabs 2008, Burston and Stichler 2010). The current system of free market, competitive tendering and budget control, together with quality measures which focus on productivity and management, seems to have increased rather than decreased pressures which move midwives away from woman centred approaches to care. Although Hunt and Symonds (1994) study of midwives work in the institutional context was undertaken almost twenty years ago, their findings, that midwives focused on the completion of work tasks rather than on the client as the centre of care, would seem to have changed little with both Hunter (2004) and most recently Pollard (2010) reporting similar findings.

There is also considerable influence in midwifery education of the institutional perspective of the NHS, with the expectation that midwives will be educated to be functional and thereby serve the goals of the employer and state (Paxton 2009). Universities are under similar pressures to those found in the NHS to deliver a product whose quality is often defined in terms of workforce requirements. There is significant emphasis in practice on competency and the development of technological skill, such that newly qualified midwives perceptorship period may focus almost entirely on skills associated with functionality from a workforce perspective, rather than development of their humanistic and caring skills.
There has also been an increase in the scope of midwifery responsibility, with midwives taking on roles previously undertaken by doctors. While some aspects of this care is potentially beneficial to women and to midwives, for example, suturing of the perineum and examination of the newborn infant, others have no doubt come from the necessity to reduce junior doctors working hours and to promote efficiency. Midwives are also increasingly being asked to specialise taking on the role of public health expert alongside that of their midwifery role.

2.5 The focus of meaning

Although the concept of excellence in healthcare can be considered from a number of different aspects such as professional (Courtney 2005), educational (Rolfe 2003), organisational (Beil-Hildebrand 2002) or surgical excellence (Carthey et al. 2003), the main focus, particularly within nursing and midwifery, would still seem to be on practice or care as a whole (Butterworth and Bishop 1995, Kennedy 1995, Irurita 1999, Gunther and Alligood 2002, Thorsteinsson 2002, Charalambous et al. 2009). Surprisingly, few have focused specifically on excellence with regard to the individual nurse, midwife or doctor.

While characteristics of individuals are frequently mentioned, other contributory factors to the provision of quality care, such as caring and the influence of moral responsibility and virtue ethics, may be deserving of further exploration, particularly in relation to midwifery practitioners. Much of the literature which is currently available in respect of the ethic of care and of moral motivation, virtue and responsibility is related to nursing and medical fields of practice. Therefore,
the following discussion considers these features in the context of midwifery practice.

2.5.1 Characteristics of the Individual Practitioner

Although the characteristics and attributes of healthcare practitioners are frequently mentioned within studies exploring quality care in health services, few focus specifically on the individual nurse, midwife or doctor or on the concept of excellence with regard to the individual practitioner. Within this study, only thirteen papers were found that focused on the person of the nurse, midwife or doctor, rather than to the more general sphere of nursing, midwifery or medicine. Of these, seven were specific to midwives (Hicks 1995, Kennedy 2000, Nicholls and Webb 2006, Downe et al. 2007, Reiger and Lane 2009, Byrom and Downe 2010, Carolan 2010), two to doctors (Tonks 2002, Duncan et al. 2003) and four to nurses (Kendall 1999, Coulon et al. 2004, Rush and Cook 2006, Brady 2009). While most of these studies did not use excellence within the title, they did make use of the concept generally, utilizing a range of terminology but including excellent within their search strategies and discussions, thereby suggesting a link with an understanding of excellence and the practitioner as an individual.

A comprehensive list of important qualities are described with as many as seventy specific qualities identified (Tonks 2002). Although many characteristics and attributes are mentioned, virtues such as respectfulness, trustworthiness, compassion, patience and caring (Hicks 1995, Kendall 1999, Kennedy 2000, Nicholls and Webb 2006, Rush and Cook 2006, Reiger and Lane 2009, Brady
2009, Carolan 2010) are most commonly featured. This is not surprising, given that personal attributes are often considered the most important elements of the best practitioners (Bassett 2002, Nicholls and Webb 2006) alongside excellent communication skills, clinical competence and professional knowledge.

However, these lists of attributes highlight the essential problem with defining excellence, particularly in regard to the individual practitioner, as participants in the discussions summarised by Tonks (2002) were keen to point out. Whilst listing attributes considered synonymous with good doctors, and for that matter good nurses and midwives (Kendall 1999, Nicholls and Webb 2006), is generally found to be relatively easy, understanding how these attributes make doctors, nurses or midwives good is less straightforward.

Byrom and Downe (2010) mention two aspects of outstanding midwives, those which fall within the psycho-motor/cognitive domain - knowledge, skill and competence, and those within the socio-emotional domain - interpersonal traits and emotional intelligence. While interpersonal traits have long been recognised as essential aspects of healthcare practice, emotional intelligence, a term commonly associated with Goleman (1999) is a relatively new approach to the global understanding of socio-emotional skills in nursing and midwifery. Emotional intelligence is concerned with how individuals recognise and manage emotions in themselves, thus facilitating better social cohesion (Howe 2008). Emotions are credited with playing an important part in practitioners ability to form relationships and communicate effectively with patients (Heffernan et al. 2010) and emotional intelligence, how an individual is able to recognise and manage these emotions, might be seen as central to this. Indeed, Kennedy (2000) suggests the ability of the midwife to care for herself, is an essential attribute of exemplary midwives.
Epstein (1999) suggests that ‘mindfulness’ or critical self-reflection, also considered within Goleman’s (1999) view of emotional intelligence, should be viewed as an essential characteristic of good clinical practice, a proposition supported by Siddiqui (1999), who terms it the need to be in tune with oneself. Such personal awareness is also considered vital for creating a healing or therapeutic relationship with mothers and can not only enhance the midwife’s ability to maintain a woman-centred focus but may also help to reduce burnout and stress (Sierpina et al. 2007).

The nurse, midwife or doctors attitude towards others, particularly from the service users perspective, is also frequently highlighted as important (Tonks 2002, Nicholls and Webb 2006, Rush and Cook 2006) with student midwives in Carolan’s (2010) study considering the midwife’s attitude towards her work, conceptualised as a work ethic, an important motivator of quality care. Brady (2009) also mentions how the children in her study were very sensitive to the body language and tone of their nurses.

Sensitivity to others, the ability to consider the other, to put oneself in their shoes and to communicate in a way consistent with this, not only maintains the humanness of the encounter but may also act as an important motivator towards action. Indeed, Maslow (1970) describes how ‘problem focused’ or sensitive individuals often feel they have a responsibility or duty to act, often describing it as a mission, something they must do. As McCarthy (2010) suggests, in these circumstances the nurse or midwife’s role may engender a feeling of increased personal responsibility for those they care for, meaning that the period of caring extends beyond what is routinely expected of them. This may be a feature of individuals who are described as ‘going the extra mile’.
The values and beliefs of individual midwives (Downe et al. 2007), particularly their belief in the normal process of pregnancy and birth (Kennedy 2000), are also highlighted alongside the need for wisdom (Kennedy 2000). Wisdom in these studies was not considered part of formal professional learning, or book learning, but linked to life experience, both within and outside of midwifery practice, the concept of phronesis or practical wisdom described by Aristotle (Gadamer 2004). This is interesting, as the foundations of midwifery practice can be found in the wise-woman of old, where practice consisted of knowledge gained through embodied experience rather than more formal learning (Donnison 1977). While formal professional knowledge is undoubtedly essential for optimum midwifery practice, it may be that the essential elements of excellence can only be achieved within a model of practice which is grounded within an understanding of wisdom as excellence.

Wisdom is considered by Baltes and Staudinger (2000) to consist of seven properties, many of which might be considered congruent with an understanding of excellent practitioners. Their description of wisdom is seen as representing a level of superior knowledge, advice and judgement, includes the ability to recognise the complexity and uncertainty of life, involves the synergy of character and mind and aims for the wellbeing or others and oneself. Finally, wisdom is recognised as being ‘easy to recognise but difficult to specify and achieve’ (Baltes and Staudinger 2000:123) representing the integration of a range of spheres of human functioning.
2.5.2 Caring

The importance of caring is frequently mentioned amongst the attributes of outstanding practitioners and the concept of caring is often associated with descriptions of excellence in healthcare practice (Woodward 1997, Duncan et al. 2003, Coulon et al. 2004). Indeed, nursing and midwifery are often labelled ‘caring’ professions, with caring seen as the basis of nursing and midwifery practice (Woodward 1997, Cheung 1998, Bassett 2002, Skott and Eriksson 2005, Rytterström, Cedersund and Arman 2009).

However, like many of the other concepts considered within this discussion, that of caring is itself nebulous and complex with multiple meanings which elude a single definition (McCance, McKenna and Boore 2001, Fine 2007, Pearcey 2010). For example, caring can be considered as either instrumental, concerned with physical care activities, or expressive and understood as a feeling or way of being (Skott and Eriksson 2005, Pearcey 2010). Although caring in healthcare is generally considered to involve a blend of both instrumental and expressive caring, it is possible for ‘care’ to be provided without any ‘caring’ being involved (Tronto 1993, Rytterström et al. 2009, Pearcey 2010), a recent criticism of healthcare that is of increasing concern.

Part of the complexity of caring, may relate to the multiplicity of contexts in which it is provided. In the past, caring activities were associated predominantly with women and took place within the context of the private domestic arena. Women were considered to be more suited to caring work than men by virtue of their gender and inherent disposition (Tronto 1993, Phillips 2007) and care was considered as a concern or responsibility towards another and traditionally
associated with ideas of duty and obligation (Slote 2007). However, as the concept of care has expanded to include paid work outside the home, this has required some adjustment in how it is understood.

One view is that professional relationships of caring, such as those encountered in the midwife-woman relationship, create a problem for caring because the underlying motivation for caring has a changed focus (Noddings 2003). Unlike the personal caring encountered in everyday life, and involving someone with whom there is already a close relationship, caring in the professional sense blurs the boundaries. The professional’s motivation for caring is one of being paid to care, or who is seen as having a socially defined role of caring, unlike the natural attitude, in which caring is personal, and this means that there is always a degree of inequality between the one-caring and the cared-for (Noddings 2003).

In modern terms, Philips (2007) view of caring as part of everyday human experience, is perhaps a more positive way of understanding care than the traditional conceptions of care as a burden or obligation. This type of relational perspective also aims to address issues of power imbalance in the caring relationship by suggesting that the care recipient, as well as the carer, are engaged in the moral basis of caring. This might also be described as a relationship of reciprocity and interdependence (Phillips 2007). Galvin and Todres (2009) also emphasise the importance of availability or ‘nursing openheartedness’ which they see as providing the humanistic ‘face’ of nursing care (Galvin and Todres 2009).

In an examination of the concept of caring, Morse and others (1990) identified five epistemological perspectives of caring - as a moral imperative or ideal, a state of human caring, an interpersonal relationship, a nursing intervention and an affect.
Caring in the context of interpersonal relationships represents a significant body of work within modern midwifery discourses and the quality and context of the relationship between the mother and midwife has been explored by a number of authors (Kirkham 2000, Page 2003, Thompson 2004a, Freeman and Griew 2007, Lundgren and Berg 2007, Hunter et al. 2008) and represents the predominant focus of caring activity in midwifery.

At first sight, there appears to have been little exploration of caring as a moral imperative, ideal or state of human being relative to midwifery practitioners themselves. Caring from this epistemological perspective has been characterised as a feeling, emotion or attitude towards another person (Pearcey 2010) and is most often associated with attributes or virtues of individuals such as compassion, empathy, presence and reciprocity. In midwifery, presence (Berg et al. 1996, Berg and Dahlberg 2001, Hunter 2002, 2009, Milan 2003, Pembroke and Pembroke 2008, Kennedy, Anderson and Leap 2010) and reciprocity (Fleming 1998, 2000, Hunter 2006a, McCourt and Stevens 2009) have been extensively discussed and compassion and empathy are frequently mentioned amongst the desirable qualities of individuals with Slote (2007) suggesting that empathy is of particular importance, forming the foundation for caring activity. However, for midwives, the high degree of empathic identification which characterises close mother and midwife relationships may be a concern, in that it can lead to feelings of stress associated with the traumatic experiences of those for whom they care (Leinweber and Rowe 2010).

Fine (2007) suggests that the distinction made between actions and dispositions is an important aspect of more recent theories of care and how the activity of care is viewed, as either a mental disposition or physical work (Tronto 1993). Tronto’s (1993) conception of care as a four stage process, an active way of being combining effort or work with a disposition or habit, suggests that caring then
becomes an ethical way of being in the world. Tronto also considers that attentiveness – a disposition towards – should be seen as a foundational element of caring.

According to Fine (2007) the ethic of care debate originated within the feminist perspective, in the work of Carol Gilligan (1982) who considered that its essential characteristic was a relational one. In this perspective, care is seen as a sense of responsibility to others, a concern for their wellbeing and for human relations in contrast to other more abstract ethical principles. Many others see caring as an ethical and moral ideal (Noddings 2003, Sumner 2010) with Phillips (2007) definition of caring as ‘a moral orientation, an ethic that guides human agency’ (2007:82) and Tronto’s (1993) view of caring as ‘both a practice and a disposition’ (1993:104).

Within midwifery, Dickson (1997) has suggested that a midwifery ethic of care should be committed to caring for women in ways which promote self-care and self actualisation, while Thompson (2003, 2004a, 2005) suggests an ‘ethic of engagement for midwifery’ (Thompson 2003:173) which focuses on a relationship between mother and midwife that reunites personal interest and morality within the care equation. Both Dickson and Thompson emphasise the importance of seeing women as individuals and of promoting relationships that are open, honest, respectful and trusting but which also involve an understanding of the midwife as integral to the care process as a person in their own right.

This is an important feature because although there is increasing emphasis on the need to treat patients as individuals (McCance, Slater and McCormack 2008), the individuality of carer’s themselves is often not considered within explorations of the care relationship (Sumner 2010). Furthermore, caring and learning to care should
be considered an evolving process which grows alongside life experience as part of human being (Cheung 1998).

2.5.3 Morality, Virtue and Excellence

The healthcare professions, particularly those traditionally dominated by women such as nursing and midwifery, have long been associated with notions of responsibility and duty and linked with the concept of a vocation or calling (Raatikainen 1997). A focus on virtues and the moral character of professionals was popular until late in the 20th century (Banks and Gallagher 2009) and while the concept of vocation may have fallen out of favour in more recent years (Downe et al. 2007), this legacy of the moral sense of ‘goodness’ lingers on within healthcare. This is evident in the language used to describe healthcare practitioners, as mentioned earlier in this discussion, with many of the attributes of good or ideal practitioners still associated with gendered concepts such as selflessness (Rush and Cook 2006), self-sacrifice (Nursing Standard 2008, Carolan 2010), devotion, obedience and meekness (Brady 2009).

For professionals such as midwives, working within the NHS in the United Kingdom (UK), practice is still largely influenced by deontological and utilitarian principles which reinforce the ideals of duty, obligation and acting for the greatest good (Armstrong 2006) and promote a culture of self-sacrifice and service as described by Kirkham (1999). Although Kirkham’s study of the culture of midwifery within the NHS was undertaken some time ago, this ‘ethic of service’ (Kirkham 1999:734) is still apparent today and often features within descriptions of ‘good’
While professional rules, codes of conduct and local and national guidelines may be important ways to maintain safety and ensure equitable care, it is clear that care that is motivated by these external factors alone falls short of what the professions would aspire to (Armstrong 2006). In midwifery, women recognise those who care by rule and those whom they feel care personally about them. Indeed, Warwick (2010) has suggested that those who adhere rigidly to rules and guidelines, and who fail to recognise the needs of women as individuals, cannot be considered good practitioners. Whilst Thompson (2003) emphasises how the challenge for midwifery is to engender moral practice from within the individual themselves, rather than through the external motivation of adherence to professional codes and guidance.

Several authors (Duncan et al. 2003, Thompson 2004a, Pellegrino 2007) have also suggested that a return to virtue ethics and to understanding the moral motivation to live the life of a ‘good’ practitioner, might be a better way to enhance clinical healthcare practice than one based on obligation or duty. Virtue ethics has its focus in the character and virtues of the individual and how they use these to live their life (Hodkinson 2008) and can be described as ‘context dependant, particularist and relational’ (Armstrong 2006:110). This fits well with a midwifery ethos of woman-centred care, whilst also recognising the contribution and perspective of the practitioner themselves.

In Aristotelian terms, the emphasis is on aspiring to be good and to live the life of a good and virtuous person (Banks and Gallagher 2009). Jacobs (2002) suggests that both Aristotle and Plato, ‘understood moral excellence’ (Jacobs 2002:51) in
terms of an individual’s desire to do the right thing and through this, to gain fulfilment and satisfaction in their virtuous actions. This provides a powerful internal motivation to act, in that the virtuous agent knows what is right and good to do and having done so feels satisfaction in having acted in the right way.

Bore and others (2005) suggest that individual differences in moral orientation may be important contributors to how practitioners care for patients and to how they resolve moral dilemma’s in their practice. Their study of medical school applicants suggested distinctive approaches in moral orientation along a continuum, such that while some might be more likely to be concerned for the wellbeing of individuals and themselves, they were also more likely to bend or ignore rules. In contrast, while others were more likely to uphold professional rules and codes, they might also tend to be reliant on these to the extent that they ignored patient autonomy and rights. (Bore et al. 2005). This obviously has significance in understanding how individuals may make decisions about how they care for patients, although it is likely that context and experience influences the extent to which they align their moral orientation with each extreme.

Goffman’s (1968) suggestion, that a person’s life can be seen as a moral career, recognises how moral orientation may change and develop over time due to the influence of internal and external factors. How individuals see themselves and their experience, combined with the influence of the social groups to which they belong and the organisations and hierarchical systems in which they live and work, mean that individuals may have to adapt to frequent changes (Kelly 1998). Through a process of reflection individuals may devise a set of guiding principles to support their decision making throughout life (McCance et al. 2008), also described by Lindh and others (2009) in a study of student nurses moral responsibility, as an ‘inner compass’ (Lindh et al 2009:133), where ideals,
knowledge and values were brought together to conceptualise the kind of nurse they wished to become. This may be consistent with non western approaches to moral development such as Buddhism, which is based on a process of continuing progress towards a state of enlightenment (Gilbert 2007).

Finally, Pellegrino (2007) draws attention to the existential perspective implied by a virtue-based approach to moral philosophy for the professions, in the distinction between ‘having’ a profession and ‘being’ a professional. Although Pellegrino is discussing physicians, and suggests that ‘being a professional is to live in a certain way, in so far as the sick person is concerned’ (Pellegrino 2007:81), this might also be related to the concept of ‘being’ a midwife (Fahy 1998, Leap 2000, Walsh 2006, Blaaka and Schauer 2008). To further this perspective of midwifery excellence would require a deeper understanding of what it is to ‘be’ an excellent midwife, particularly from the mothers perspective.

2.6 Implications for this study

The discussions within this chapter suggest that the concept of excellence is complex and multi-faceted with the many interesting perspectives related to its use adding to the difficulty of providing one definitive understanding of the meaning of excellence. Like many other concepts in healthcare, such as caring or expertise, these complexities continue to exist, defying attempts to reduce them to one overarching definition. Perhaps therefore, the most important feature on which to focus is the context in which excellence is used because, as suggested by Readings (1997), its meaning may only be understood in terms of what those
describing it understand it to be and this may vary considerably between individuals, groups and organisations.

What the literature does highlight is that while features of excellence have been explored within services as a whole or within professional roles, thus far, there has been very little focus on excellence within the context of the midwife themselves. While some attempts have been made to list the qualities, attributes and characteristics of excellent or outstanding individuals, how these contribute to an understanding of excellence is still not clear. Furthermore, although excellence has been suggested as a feature of the individual, a ‘special quality’ (Kendall 1999) that some individuals possess, what this actually consists of still remains elusive. Consequently, although excellence may be easy to recognise, it would seem that it is still difficult to describe, particularly with regard to why some individuals are considered excellent, while others are not.

The focus of the study is therefore:

‘A hermeneutic phenomenological study exploring pregnant and birthing women’s understanding of the meaning of an excellent midwife’

The aims of the study are primarily exploratory, focusing on midwifery excellence at the level of the individual and seeking to understand what makes some midwives ‘stand out’ amongst their peers and what it means to be an excellent midwife from within the perspective of twelve women with lived experience of midwives and midwifery care.
The Research Approach

3.1 Introduction

While a research method might merely be thought of as a way of investigating a question, the way in which questions are asked and understood are important starting points (Van Manen 1990), and reflect the need to maintain harmony between the methods chosen and the worldview of the researcher themselves. In this case, my choice to utilise a hermeneutical phenomenological approach in understanding midwifery excellence, can be seen as consistent with my own worldview of midwifery practice, at both a personal and professional level. As Van Manen suggests, midwifery practice itself requires that midwives have a degree of ‘phenomenological sensitivity’ (Van Manen 1990:2), an ability to understand the experiences of the women for whom they care and to interpret these experiences within the medium of language. Thus, this propensity for understanding through human experience and for dialogical interpretation of that experience might already be considered to be deeply embedded within my own practice and considered an everyday way of approaching the world.

However, although a phenomenological approach is widely used in healthcare research and has become the dominant discourse within the development of nursing knowledge (Dowling 2007, Bradbury-Jones, Sambrook and Irvine 2009), the term phenomenology is often used without consideration of the significant philosophical differences demonstrated by individual approaches to it (Walters 1995, Dowling 2007). Phenomenology does encompass many diverse opinions

While Husserl considered phenomenology from an epistemological position of ‘knowing’, his pupil and later critic Heidegger’s approach was ontological, grounded in the question of ‘being’ itself (Wraithall 2005). Consequently although Husserl advocated a distancing from the world and from the reality of experience in order to take a step back and look at it anew, in contrast, Heidegger proposed that, as beings in the world, we cannot suspend our pre-knowledge and understandings to step outside a phenomenon.

For Heidegger, there was ‘no such thing as uninterrupted fact’ (Walters 1995:795) and this leads to one of the most striking differences between the approaches of Husserl and Heidegger, the notion of where we stand as human beings and subsequently as researchers. Such an understanding is essential if researchers are to ensure that the methods chosen are consistent with a specific philosophy (Vivilaki and Johnson 2008).
3.2 Hermeneutic Phenomenology – Husserl, Heidegger and Gadamer.

The modern movement of phenomenology is widely considered to have begun with Edmund Husserl (1859-1938), a mathematician living in Germany prior to the First World War. Husserl was widely influenced in his thinking by the philosophies of earlier times, and considered his approach to phenomenology to be rooted within the science of absolute knowledge (Walters 1995). Husserlian phenomenology is primarily concerned with the epistemological question of what it means to know and experience is recognised as the basis of knowledge (Draucker 1999). Husserl’s own classification of phenomenology as transcendental, was based on his view of phenomenology as a science of phenomena, the understanding of ‘essences’ (Annells 1996). Thus, Husserl considered phenomenology to be a study of consciousness and believed that, by bracketing out objects outside the consciousness itself, knowledge of our world, grounded in our lived experience, could be examined without interference from the subjective elements of that experience (Wrathall and Dreyfus 2009). In order to do this, Husserlian phenomenology requires the integration of three distinctive notions – intentionality, essences and bracketing (Koch 1995).

Intentionality has occupied a central role within modern phenomenology, although its status and precise nature have been controversial (Mohanty 2009). For Husserl, intentionality was represented in the assumption that all mental acts are related to an object (Dowling 2007) and he therefore considered that awareness of our own consciousness was the one thing we could really be sure of. Husserlian phenomenology adopts Cartesian duality or the mind-body split (Koch 1995, Crowell 2007) and thereby considers that it is possible to separate out and
examine the ultimate structures or ‘essences’ of human consciousness, a feature
which I do not consider possible. The suggestion is that moving outside the world
or out of the pre-reflective consciousness of everyday into the transcendental,
allows for consideration of the pure essence of experience within the cognitive
mind (Tapper 1986). Together with bracketing, or phenomenological reduction (a
process of removing or suspending any presuppositions or consciousness of the
outside world) the proclivity for interpretation is thereby removed, leaving a purely
descriptive account of the experience, in effect, making Husserlian
phenomenology objective and scientific (Paley 1998).

Heidegger’s view, and one with which my own is more consistent, was very
different, given that he rejected this Cartesian view of phenomenology, together
with Husserl’s objectivity and notion of intentionality, in favour of his own term for
the entity of humans, what he named ‘Dasein’ (Heidegger 1962). Dasein is used
by Heidegger as a term for describing not only what human beings ‘are’ but also
the kind of being humans ‘have’ (Inwood 2000), in other words, his use of this
word describes how everything we do is related to the style or manner in which we
exist and act within the world (Wrathall 2005). In ‘Being and Time’, his celebrated
philosophical work originally published in German in 1927, and shown here from a
later English translation, Heidegger states:

“Dasein always understands itself in terms of its existence – in terms of a
possibility of itself: to be itself or not to be itself. Dasein has either chosen
these possibilities itself, or got itself into them, or grown up in them already.”

(Heidegger 1962:33)
Heidegger therefore considers that ‘an understanding of the person cannot occur in isolation from the person’s world’ (Walters 1995:792) and unlike Husserl, he does not see understanding as a cognitive act but rather a way of relating to the world (Wrathall 2005). My understanding of this is that the context in which we are born, grow up and subsequently live our lives is integral to our being, and to understanding each of us as individuals. Moreover we can only make sense of our world within the framework of interaction, communication, interpretation and re-interpretation, meaning that knowledge of the world is personal, individual and therefore, subjective.

Heidegger was also instrumental in transforming previous ideas relating to the use of the hermeneutic circle, such that it changed from being seen as a theory or method for textual interpretation to become rather, the means by which the basic structures of factical existence might be explored (Malpas 2009). Similarly, Hans-Georg Gadamer (1900-2002), a colleague of Heidegger’s and a decisive figure in the further development of hermeneutics, rejected attempts to ground understanding in any particular set of rules or method and stressed the limitations of their use. Instead he focused on understanding as a practical, situated and dialogic activity (Malpas 2009).

Gadamer’s approach focuses specifically on the importance of language to the process of understanding and in his work ‘Truth and Method’, Gadamer (2004) like Heidegger before him, suggests that understanding is always based on pre-knowledge of something. This means that experience can be seen to represent two approaches, either confirming what we already know or leading us to view the experience in a new light, by showing us that we have not previously understood something correctly and may now know it better.
“We cannot, therefore, have a new experience of any object at random, but it must be of such a nature that we gain better knowledge through it, not only of itself, but of what we thought we knew before… we call this kind of experience dialectical”

(Gadamer 2004:348)

In this way, Heidegger and Gadamer stress the historicity of our being, drawing attention to how understanding is constituted of both knowledge of past, as well as present, in a fusion of horizons (Crotty 1998). In phenomenological terms, this suggests that an individuals experience of past events is merged and blended with the present to form a new understanding of that experience and thus, through a process of dialogic interpretation, experience is always an interpretation based on something already known. This is an important consideration within this research study, as my own experiences of midwifery practice and any previous understanding of midwifery excellence, alongside those of the women taking part, form the basis from which any new understanding is reached.

Furthermore, since truth, in the view of both Heidegger and Gadamer, might be considered to be just how things ‘are’ for individual beings, given their spatiality and temporality, this may differ significantly between one person and another (McConnell-Henry et al. 2009). This effect is evident in the differing stories that individuals often recount relating to a shared event or experience. It is not that these individuals are not being truthful, but rather it represents their own interpretation of the situation as they experienced and continue to experience it.

With these features in mind, each of the women participants in this study has an experience to offer which is unique, situated and contextual, by virtue of their previous experience, expectation and perception. It is also an interpretation affected by their own internal dialogue and mood, as well as the external influence
of others in their lives - partners, mothers, sisters and friends, in much the same way as my own. In research terms, this means that in the very act of recounting an experience, new insight and new understandings may be gained. Therefore, the act of engaging in dialogue with self and others might be considered a central feature within the discovery of new understanding.

3.3 Phenomenology and group methods – the issue of compatibility

While individually, both phenomenology and group methods such as focus groups, have become increasingly popular in healthcare related research, the use of group discussion methods within phenomenological studies is still relatively uncommon. Although there has been some debate previously in the academic nursing literature over the compatibility of combining group methods and phenomenology, with some like Webb and Kevern (2001) suggesting that group methods are wholly incompatible with phenomenological research, Halling and Leifer (1991) and more recently Bradbury-Jones and others (2009), feel that group methods are not only compatible, but may potentially enhance the quality of data collected. The dichotomy at the heart of this argument is perhaps reflective of a lack of philosophical justification for their use alongside phenomenology within those studies where the two have already been combined, a view supported by Bradbury-Jones and others (2009).

Traditionally therefore, although the methods chosen for collection of data in this study, are not usually associated with phenomenology – group interviews, online
data collection and the use of simple software (email) for the group discussions, my understanding is that they remain true to the underlying values and principles expounded within the philosophical ideas of Heidegger (1962) and Gadamer (2004).

Since phenomenology seeks to understand an individual's experience from their own unique perspective (Van Manen 1990), the suggestion is that group discussions, with their focus on the group's experience, rather than on an individual's experience (Sim 1998), contaminates this perspective (Webb and Kevern 2001). However, while this may be a true reflection of phenomenology proceeding from a Husserlian perspective, a Heideggerian hermeneutic approach is concerned with the shared interpretations and experiences of beings-in-the-world (Walters 1995) and therefore, data collection methods involving groups might be seen as wholly compatible with this perspective. Furthermore, the hermeneutic circle provides a way of moving dialectically between the totality of experience and its constituent parts in order to more fully explore the phenomenon under consideration (Koch 1996) and to therefore recognize the individual perspective amongst the group discussions.

Heidegger's interpretative approach to phenomenology already considers contamination of an individual's experience, through discussion and interpretation with others, as an inevitable part of being human (Bradbury-Jones et al. 2009). Consequently, group methods might also be considered a way of stimulating and encouraging discussion, with the variety of perspectives found amongst individuals potentially providing a richer pool of data for interpretation. Researchers who have tried group approaches within phenomenological studies, like Halling and Leifer (1991), suggest that what they called a 'dialogical phenomenology', was highly beneficial, providing greater insight, discussion and challenge within their research.
themes. Furthermore, group discussions might also be considered more representative of the actuality of how people live and thus communicate their experiences within everyday life.

From my own perspective, this is evident in the approach to my own study, where women’s experiences and their discussions about midwives in particular, are situated within the context of the thoughts, experiences and reflections of the other women in their lives - mothers, sisters and friends. The discussions within the groups highlights the influence of everydayness, in effect bringing a wider circle of women’s experience into their discussion, through the use of other women’s opinions and experiences as a reference point for and of their own perspective.

Therefore, the use of the email group has value in this context because the collective nature of the inquiry is merely reflective of the usual state of affairs for women’s ways of understanding their world. This is a view supported by others like Cote-Arsenault and Morrison-Beedy (2001) and is seen as particularly important in feminist research studies like those by Madriz (2003) and Kookan and others (2007). Heideggarian hermeneutic phenomenology is interested in the inter-subjective shared interpretations and experiences of being-in-the-world, and does not see the experience of the individual as providing an absolute or true account but rather a more tentative one (Walters 1995).

3.4 Conclusion

Since this discussion has shown that a Heideggarian or Gadamarian phenomenological approach is not concerned with, but rather emphasises the blended nature of interpretation and does not agree that pre-suppositions and pre-
knowledge can ever be put to one side, the main criticism against group data collection methods in phenomenology – data contamination – is somewhat obsolete. That is not to say that researchers should not concern themselves with the quality of their data, but rather that other forms of verification, such as transparency, should be used to enable readers to make their own judgements and interpretations of the research process. Furthermore, because the perspective of both Heidegger (1962) and Gadamer (2004) see the researcher as part of the participant’s experience of being-in-the-world, the researcher also adds to that experience through a process of evolving interpretation, or what might be called dialectical discovery.

In general, people do not keep a running journal of their life experience by which to judge if their view of the realness of an event has changed over time, and because other peoples stories and interpretations may also be blended into this memory, I would consider there to be a degree of futility for any researcher seeking access to the absolute truth through research interviewing. If we believe, as does Heidegger, that facts cannot ever be separated from interpretation, questions related to demonstrating the truthfulness of participants also become obsolete. Therefore, the choice of an online email group method within this phenomenological approach may be at worst, only representative of the everyday contamination of experience that is present in everyday life.
4 Research Design

4.1 Introduction

There is some debate within the academic research community regarding the ‘proper’ way to undertake qualitative research and while there are some (Denzin and Lincoln 2000, Johnson, Long and White 2001) who argue for the benefits of ‘pluralism’ within the qualitative paradigm, others suggest that modifying or mixing methods results in a lack of rigour which ultimately weakens the research and may even invalidate it (Maggs-Rapport 2001, Cutcliffe 2005). This is perhaps not surprising given the range and diversity of approaches represented within the field of qualitative research (Atkinson, Coffey and Delamont 2003) however, while having a step-by-step formula to guide the design and data collection within a study may be reassuring, especially to the novice researcher, simply following a process will not ultimately result in good research.

Denzin (1970) suggests it is the choices, values and personalities of individual researchers which ultimately contribute to the way in which research is approached. From this perspective, therefore, the fundamental beliefs of the researcher have a major impact on all stages of the research process, beginning at an early stage with the type of question, the way it is being asked and progressing all the way through to the final analysis and presentation of findings. In this study, an understanding of reality as individual, situated and contextual, supports the belief that there may be many different ways in which to approach any research study and thus many different interpretations made (Appleton and King 2002).
The design of this study is therefore, not only heavily influenced by my ontological beliefs as discussed in the last chapter, but also by my life experiences which feature such reflections as the problems associated with interviewing women about their breastfeeding experiences with their baby also present (during my MSc project) and my growing interest in the internet as a medium for qualitative data collection. These reflections, along with others, including pragmatic decisions required due to the limits of time and finance, have had a significant impact on the research design.

As the main aim of this study is to discover more about the meaning of an excellent midwife, particularly from the perspective of women service users, I have chosen to use an asynchronous group discussion method, each group conducted over a period of weeks and online using email as the mode of communication. The following discussion is offered to illuminate my journey through the research design and to offer readers an opportunity for understanding the basis on which decisions regarding research methods, including the development of a modified approach to online group discussions, have been made. This may also offer readers a way to contextualise my position within this research inquiry.

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1 Asynchronous relates to non-real-time communication online, where participants are not required to be online at the same time. The sender transmits a message that can be read and responded to at some time in the future (Mann and Stewart 2000).
The development of new approaches for the collection of qualitative data provide opportunities to combine the best features of more traditional methods with those found within newer environments, such as the virtual one. However, although the internet is being used more often for healthcare research, the combination of online data collection and group methods is still relatively unusual (Bradbury-Jones et al. 2009). Considered separately, and in combination, both group discussion and online methods have features which are suited to the aims of my own research inquiry; however they also represent significant issues in application that may often preclude their use for small scale research studies such as this.

Some researchers have combined both group methods and online data collection with good effect (Eke and Comley 1999, Oringderff 2004, Kenny 2005, Turney and Pocknee 2005, Kralik et al. 2006, Im et al. 2008) and it was their experience which encouraged me to consider online data collection as a useful approach for exploring the meaning of an excellent midwife. Furthermore, the potential benefits related to online research, explored in greater detail later in this chapter, also suggested that this would not only provide an opportunity for collection of context rich data regarding women’s experiences of excellent midwives, but that it would also do so in a way that might help reduce the burden of commitment for women participating in the study.

The discussion that follows is an exploration of the background and current use of both group methods and online qualitative data collection, with an explanation of
the reasons for the development of a modified approach to qualitative data collection used within this study - Email Group Conversations.

4.2.1 Group methods for collecting qualitative data.

Amongst a number of group methods available for collecting data, focus groups are perhaps those most frequently cited. Robert Merton is considered to have been the first to use focus groups for social science research, with his pioneering work in the early 1940’s on people’s reactions to wartime radio broadcasts (Puchta and Potter 2004), and focus groups have since been used in market research for many years (Bamford and Gibson 2000, Kenny 2005). In healthcare, although the use of focus groups, particularly for clinical research took some time to be adopted as a mainstream method for data collection (Webb and Kevern 2001) they are now more commonly used to explore the user perspective (Cote-Arsenault and Morrison-Beedy 2001, McCallion and McCarron 2004, Kooker et al. 2007). The use of focus groups provides major insight into beliefs, attitudes and opinions and may also pay more explicit attention to the views of consumers and the value of their contribution (McLafferty 2004). This is particularly relevant in this study, as the ability to seek the perspective of healthcare consumers, in this case, childbearing women, is an essential consideration within the research design.

Furthermore, while group methods such as focus groups can be just as useful in collecting in-depth qualitative information as other methods such as interview, observation and diary writing (McCallion and McCarron 2004), in contrast to these, the main benefit of using a focus group to collect data is thought to be the
interaction of participants. Interaction is the key, and it is this opportunity afforded by the structure of the group discussion which results in a high level of face validity, as participants can confirm, contradict or reinforce what they say within the group (Webb and Kevern 2001).

Focus groups usually contain between four and twelve participants (Kreugar and Casey 2000), with smaller groups being easier to recruit and facilitate and allowing more discussion amongst individuals (Turney and Pocknee 2005). However, these benefits have to be offset by the limited scope of experience found amongst four in comparison to twelve participants, and small focus groups are therefore better used when there are more than one or two groups planned, as in this study. There is also some divergence in opinions as to the correct use of a focus group method for data collection and other methods such as the Delphi technique may be considered more appropriate when the aim is for concurrence of opinion (Kennedy 2000, Powell 2003, Kennedy 2004). The Delphi technique is a multi-stage, iterative process which aims to combine perspectives into group consensus (Hasson, Keeney and McKenna 2000), however, this also means that they may be less able to represent the perspective of the individual.

Focus groups have many features which might make them highly suitable for use in this study, however, they also have a number of major disadvantages. Focus groups require participants to attend at a specified time and at a venue suitable for a group meeting (Kreugar and Casey 2000), a feature which places considerable time and travel burdens on potential participants. In this case, I felt that women with very young babies and children might struggle to attend at all. In addition, finding a venue with facilities suitable for young children or with childcare provision in a convenient location would be challenging and would necessarily limit the geographical location of women taking part.
4.2.2 ‘Virtual’ Research – collecting qualitative data online

While the potential of the internet as a research tool has been widely recognised and used for survey research for a number of years, its use for data collection in qualitative research is still relatively new, however, this is likely to increase dramatically as the potential benefits are recognised by researchers (Im and Chee 2002, Hine 2005). Use of the internet, particularly amongst women, who value its potential for social networking, has been growing with many women now seeing it as a normal part of their everyday life (Im et al. 2008). Furthermore, online communication has the additional benefit that it may allow those unable or unwilling to travel to take part in discussions, and therefore reduces issues of geography (Kralik et al. 2006) and time, as individuals can choose to contribute at times which suit them.

In addition, the anonymity afforded by online research methods has been shown to considerably increase the willingness of participants to disclose information that might not be offered in more traditional, face-to-face methods, particularly when topics under discussion are sensitive or prone to censorship through peer group (Mann and Stewart 2000) or social (Sanders 2005) pressure. While this is not likely to be a major issue within the design of this study, the level of anonymity also provides an opportunity to consider an individuals contribution without the usual visual clues, such as physical appearance, accent or age, usually associated with face-to-face methods. In this case, it also means that the women’s words, rather than their appearance, is given priority, a feature consistent with the hermeneutic basis of this study.

However, the use of online communication, like many other methods, is not
without its disadvantages. Since the major proportion of communication is transmitted in the non-verbal format, online communication methods significantly reduce the amount of social information available to the researcher and to the other participants within the groups (Mann and Stewart 2000). Therefore, there is greater potential for misunderstanding as the non-verbal cues - facial expressions, tone of voice and body language, that normally accompany face-to-face discussions, are unavailable (Oringderff 2004). The role and skills of the facilitator and meticulous attention to the nuances of communication online is therefore of utmost importance.

4.2.3 Email Group Conversations

While some researchers have combined group methods and online data collection (Oringderff 2004, Kenny 2005, Turney and Pocknee 2005) these represent a variety of strategies within the ‘virtual’ environment. Some have used online focus groups, facilitated both in real-time and in non-real time, however, these generally rely on the use of ‘conference sites’ (Mann and Stewart 2000:102) and require specific software that individual researchers do not usually have access to. In addition, real-time or synchronous groups have many of the problems associated with traditional face-to-face focus groups, as individuals are required to be online at specific times and the immediacy of them means that participants may find it difficult to follow fast paced ‘conversations’, have little time for reflection and may limit the participation of those with slower reading and typing speeds (Turney and Pocknee 2005).
An alternative is to use a non-real-time or asynchronous approach, which includes person to person emails (Kralik, Koch and Brady 2000, Kivits 2005) as a form of online interviewing, or multiple email groups such as ‘list servs’, news or discussion groups which allow individuals to subscribe to a topic group and which hosts email discussions (Mann and Stewart 2000). In this format any emails sent to the list address are automatically sent to all other subscribers and this is the method used by Kralik and others (2006) during their exploration of living with chronic illness, a process which they also tentatively title email group conversation. This allows all participants to see the whole discussion and comment as they wish. The disadvantage of this approach is that participants emails addresses are visible and there is a risk that ‘conversations’ may occur outside of the research study as participants may bypass the discussion group in favour of direct communication with each other.

Eke and Comley (1999) describe a method which they call moderated email groups or MEG’s, and this is very similar to that used within my own study. They also use both an asynchronous approach and email as the basis of the group discussions, with all the emails being sent to the group moderator rather than to participants directly. However, within MEG’s, emails are then compiled into a summary which is sent back to the participants. In this way, participants only see the content considered important and therefore selected by the moderator. In MEG’s the moderator controls the discussion and decides what is worthy of further exploration.

My own development of Email Group Conversations borrows from both Eke and Comley (1999) and Kralik and others (2006) using email, a simple piece of software that the majority of individuals with internet access will already be using. However, it is different, and represents a fusion of these two methods, in that all
communication sent to the group facilitator is circulated in full, by blind copy format, to all group participants. In this way, the women taking part are able to read the whole ‘conversation’ of the others within their group and thus the group, rather than the facilitator, is able to decide the content and therefore has more control of the discussion. It also removes the issue of discussion outside the group as none of the participants have each others email addresses, the facilitator being the only visible address within communications. Furthermore, unlike ‘list serv’ groups, which may have large numbers of participants, the group numbers are limited to a maximum of five participants and this reduces the volume of communication, a feature which Kralik and others (2006) report was sometimes difficult for participants to manage. It may also enhance cohesion within the group and so promote better group dynamics and thus exploration of individual perspectives, and is perhaps closer to the format of the more traditional focus group.

An additional benefit is that because all communication is in written format, all contributions contain equal weight, therefore the potential for domination of the group by one very vocal individual, as in more traditional focus group methods, is reduced. Moreover, the opportunity to explore issues over a period of time and to revisit the subject on subsequent occasions may give a more accurate perspective of the topic (Fern 2001) than a one time interview, which generally only samples the participants’ opinions on a single occasion.
4.3 Ethical considerations in online research

Although this research study took place in the virtual environment with recruitment within the public arena and therefore NHS research ethics approval was not strictly required, there are still a number of ethical issues, many of them not specific to researching online, such as confidentiality and privacy, but which are more problematic in the often ambiguous online environment (Sharf 1999). For these reasons I felt that an independent review would be beneficial to ensure that any major ethical issues were fully addressed within the study design and it was submitted for a full ethical review and agreed by an NHS Multi-site Research Ethics Committee. The following discussion explains how the ethical issues arising within this study were addressed.

4.3.1 The Study Website - Informed consent within the ‘virtual’ environment

The provision of detailed participant information is an important feature of research design so that potential participants understand and can identify with the topic under investigation, are fully aware of what is involved within the research study and know what their own involvement will be. It is also important to ensure that they are aware of their rights with regard to volunteering for a research project, such as how they leave the study if they wish to and what will happen to any data collected up to that point (Mann and Stewart 2000). In this way, participants should have all the information they need to decide if they would like to take part.
In my own study, the online nature of the design provided both an opportunity and challenges in obtaining informed consent from participants, as the ‘virtual’ environment precluded actual written consent and required development of an online version instead. Despite these issues however, the online environment did provide an excellent medium for presenting participant information through the provision of a study website (see appendix 1), which was developed and hosted on the University student web facility. The website provided information and also an opportunity to ask further questions via an email link and also contained the online consent form for participants to complete. The link to this website was included in the advertisements for participants and thus, women considering if they wished to take part could visit the study website to obtain a more detailed explanation of the aims and design of the study before volunteering to take part.

4.3.2 Confidentiality, Psychological Comfort and Accessibility

Ensuring total confidentiality in online communication, without the use of encryption is not possible (Duffy 2002). However, the use of encryption presents its own disadvantages, as participants require complex software which may exclude many potential participants and reduce accessibility to the research process. In light of this, Mann and Stewart (2000) suggest that full disclosure of these issues to participants is paramount, so that participants are aware, before they consent to take part, of any potential risk of unauthorised access to their communication and any protective measures in place to minimise these risks (Fischbacher et al. 2000, Coleman, Evans and Barrett 2003). These risks were identified clearly within the participant information on my study website and the
group discussion emails were stored electronically and password protected, while all research extracts are identified by coded pseudonym.

The potential for causing participants distress through discussion of experience, particularly since I was removed from actual contact, was also considered, and an alternative contact with midwifery experience, was also provided via a direct link from the study website, should they wish to communicate with someone other than myself. While available literature in this area is still somewhat sparse, none of the online study’s that I examined (Fischbacher et al. 2000, Adler and Zarchin 2002, Kralik et al. 2005, Im et al. 2008) reported any problems of this kind however, since women’s experiences of birth can sometimes be distressing it is important to ensure that there is support available if required.

Perhaps one of the major concerns of using online group methods of communication, and one of the main considerations within my own design, was the risk of harassment of individuals within the group by inappropriate language, also called ‘flaming’, and volume bombardment where individuals are overloaded with multiple emails (Jones 1999, Mann and Stewart 2000). These issues are often discussed under the term ‘netiquette’, a way of describing the accepted kinds of behaviour specific to communication in the online environment. In order to reduce the risk of these problems, in my own study, use of the blind copy format (email addresses not visible to recipients) and small group size aimed to reduce the potential for these issues.

Finally, a major concern when conducting internet research are those associated with access which may be limited in online studies and preclude some individuals from taking part due to their unfamiliarity with the technology involved or with lack of access to computers and online environments (Mann and Stewart 2000). This is
an issue which requires consideration in the design of any research study however, because all research designs present limitations to potential participants in itself this is not an issue that I felt precluded the use of an online method in this situation. Therefore, the design of the study specifically chose to use email, a simple form of online communication that many people are already familiar with and moreover, as the study was considered exploratory, it was not therefore seeking to recruit women from any specific social group. In addition, it is recognised that while online methods may disadvantage some women it may actually support others in taking part, especially those who are unable to travel, as shown by Adler and Zarchin (2002) in their study of pregnant women on home bed rest, and by Kralik and others (2006) who used an online method to offset issues with geographical location and time availability. In addition, Turney and Pocknee (2005) identify how they were able to specifically target single mothers with childcare responsibilities by using an online approach in their own study.

4.4 Inclusion Criteria and Recruitment Strategies

The inclusion criteria for the study were - the minimum age for participation being 16 years of age, with no upper limit. Participants were also required to have their own email address and were asked to check their emails at least once a week. Since I was initially seeking a range of perspectives amongst health care users I did not deliberately choose to recruit only those of childbearing age or with recent experience of birth, however, many of the sites where the advertisements and study information were posted were most likely to be viewed by women currently having babies or young children. In the same way, I hoped that a range of
professionals, midwives and those connected with midwifery, would also take part and share their views with information disseminated through professional websites and publications.

Since this was an exploratory study and used a qualitative methodology recruitment was purposive, that is, sites were chosen that would be representative of the range of perspective I was seeking and required that participants have experience of midwifery practice as a service user or as a maternity care professional. Initially, I chose a few well known professional and non-professional sites, representing a range of perspectives that I felt would provide the diversity that I was seeking, for example, The Royal College of Midwives (RCM), Heads of Midwifery Forum, Royal College of Nursing (RCN) Midwifery Society, Royal College of Obstetricians and Gynaecologists, (RCOG), General Practitioners Forum, MIDIRS, National Childbirth Trust (NCT) and a some other mother and baby magazine sites. All of these sites were contacted by email and the research aims outlined with a request to include some information and the study website address within their news, research or chat facility.

The study website was designed to provide enough information so that potential participants could make an informed choice prior to agreeing to take part. It also allowed them to contact me for further information if they wished to discuss anything further, although during the study time period of 2005/2006, none of the participants used the 'contact me for further information' facility. The website also contained an online consent form, which was emailed directly to me from the site once they had completed it and clicked on the submit button. Following this I contacted them by email to confirm that they still wished to participate before assigning them to a discussion group.
4.5  Understanding the participants

The twelve women taking part in the study were volunteers recruited via advertisements posted on mother and baby online magazine sites and represent a self selected sample of women with personal experience of birth and midwives and with an interest in discussing the meaning of an excellent midwife. As far as I am aware, none of the women knew each other prior to the study and none of them were known personally to me. Although all but one of the women had experience of maternity services in the UK, predominantly within the NHS, the geographical locations of those experiences are also unknown and may have taken place in any part of the UK. One woman taking part lived outside the UK and her experiences therefore reflect her experiences of birth and of midwives in Canada. Women volunteered to take part over a number of weeks and were therefore allocated to a group as they volunteered, resulting in three separate e-groups (Appendix F).

Group 1 consisted of four women – Nina, Vicky, Sophie and Jenny, all of whom were non healthcare workers. Two of the women were pregnant with their first child, while the remaining two had one child and had given birth within the NHS. In this group, one woman (Jenny) left the study at an early stage, citing lack of time as the reason.

Group 2 had five participants – Kate, Karen, Susan, Heather and Hazel, four of whom were non healthcare workers and one, Kate, who was a mental health nurse. One of the women in this group was also an NCT (National Childbirth Trust) ante natal teacher and trainee doula. All five women had given birth, two in an NHS hospital (Kate and Heather) and two at home, one with an independent
midwife (Susan) and one with NHS midwives (Hazel). The final woman in this group (Karen) had experience of three births, the first in an NHS hospital, the second at home with an NHS midwife and the third at home with an independent midwife. In this group two women were studying part time but did not give other information about their occupation.

Group 3 had three participants – Nadine, Sara and Tania, two of whom had experience of birth in an NHS hospital with the third currently pregnant and living in Canada. Two were non healthcare workers and one was a general nurse. One woman in this group worked as a science technician, while the remaining member did not state her occupation.

The women were aged between 21 and 45 years at the time of the study and were all either married or living with a partner. The ethnicity and social backgrounds of the women are not known. All the women had regular access to an email account and the email conversations were all conducted in English. Although the women were not asked to describe their birth specifically, many did so during their discussions of excellent midwives and this suggests that a range of birth experiences is represented amongst the women taking part. At least two of the women had their labour induced due to pregnancy complications (Kate and Heather in Group 2), while one woman described a caesarean section birth (Kate) and several others vaginal births. Although the majority of the midwives identified by the women as representing an excellent midwife were female, as would be expected within a female dominated profession, one midwife described as excellent within the study was male.

The care setting was also varied and it is evident from the women’s discussions that while some of the women got to know their ‘excellent’ midwife during the ante
natal period and had care that continued with the same midwife during birth and in
the post natal period, most of the women received care from a variety of different
midwives and were cared for by those that they identified as ‘excellent’ for shorter
periods of time, in some cases only a few hours. Therefore, in this study, midwives
described as excellent are identified within a range of care settings, hospital, home
and independent practice and within various models of care.

4.6 Phenomenological Data Analysis

The data within this study are analysed in the phenomenological style of Max Van
Manen (1990). This requires consideration of the women’s texts within the context
of the woman herself, as well as within the group as a whole and eventually,
across all three discussion groups. This approach also provides a feel for what
women contribute to their own evolving discussion and understanding, as well as
how their discussion contributes to the experiences related by other women in the
group.

Initially, each woman’s comments are read through several times to get a feel for
what they are saying on an individual level (example transcript appendix B) and a
wholistic approach (Van Manen 1990) taken to consider what their discussion as
whole represents. This is constructed in the form of a short summary of each
woman’s conversation (see appendix C), using their own words, as shown in the
following example:
Heather, Group 2 – Individual Summary

I had to be induced two weeks early due to obstetric cholestasis, not the most pleasant of experiences as each procedure was not taking the full effect. Then, on the early shift along came Clare. She was confident, instilled a sense of knowing what she was doing and started to take control and get things moving. It took the top dose of drugs to start the contractions and the baby was not very happy about it. Clare continually monitored both of us, kept my husband happy and occupied, had a sense of humour and yet she was not obtrusive and she was clinically correct with all her predictions. She knew when to offer help and when to step back and let me get on with it. All in all it was such a good experience of something I felt could have gone so wrong but was made possible by the midwifes competence and skill.

We are all individuals and all have different expectations. Midwives differ – it begs the question is it training or the persons character – is it nurture or nature? My feeling is that some people could be trained forever and never get it right, and who tells them? Is it us, or their manager? For some, caring, intuition and listening comes naturally before skills and competence and that is what counts.

It’s really about what people want and to be listened to. How is that achieved – through core values? Core values are hard to define – guiding principles, guidelines, codes of conduct but again it comes down to the individual. How do we monitor them (and who monitors) this whole process? Its true there are systems and a governing professional body but who has set all the rules and regulations – is it actually the people who need and use the service or is it people who think they know what we need? We would all love excellence, maybe if we are listened to that may help.
Each individual’s text is then read through in detail, focusing initially on each participant’s contributions over the entirety of the group conversations and every sentence considered separately with notes made alongside, which attempt to capture the main focus of that sentence. The example below shows how an extract from Heather’s text is considered in detail, line by line.

**Extract - Heather Group 2 – 2147 hrs  Line 51 – 61**

‘The other point is the midwife themselves. It is obvious it varies from person to person and that begs the question is it the training or the person’s character. Is it nurture or nature. Ongoing development is always good but for some people we could train them forever and they may never get it just right! And who tells them, us, their manager? And should we expect the individual to go beyond the call of duty and not get paid for it, should we survive on good will? Which brings me back to my thought that I think for some people caring, listening and intuition comes naturally before skill and competence and that is what counts?’

Sentence 1 - ‘The other point is the midwife themselves.’ In this sentence Heather emphasises an understanding of the midwife as an entity outside of, and/or alongside her professional role.

Sentence 2 - ‘It is obvious it varies from person to person and that begs the question is it the training or the person’s character. Is it nurture or nature.’ Heather recognises that midwives are very different and considers if this is a feature of the midwife’s professional training or of their character.
Sentence 3 - ‘Ongoing development is good but for some people we could train them forever and they may never get it just right’ – Heather considers that its not just about training, in fact for some, no amount of training will help. ‘It’ might therefore be considered a feature of the individual.

Sentence 4 – ‘And who tells them, us, their manager?’ This sentence suggests that expectations may be variable, and therefore what women and midwife managers consider important might be very different.

Sentence 5 – ‘And should we expect the individual to go beyond the call of duty and not get paid for it, should we survive on good will?’ Here, Heather asks if it is reasonable to expect midwives to do more than their ‘duty’ expects, perhaps from altruistic desire rather than financial gain.

Sentence 6 - ‘Which brings me back to my thought that I think for some people caring, listening and intuition comes naturally before skill and competence and that is what counts?’ Heather concludes that some people have a natural disposition towards caring, listening and intuition which comes before skill and competence and that is what counts.

When considered as a whole these two approaches, the wholistic and detailed line-by-line approach (Van Manen 1990) show that Heather sees excellence as a feature of the individual, a natural disposition towards being caring which means that they act in ways that go beyond what is required of them by duty alone, described by Heather as a ‘core value’. So, although Heather does feel that professional knowledge, competency and skill are important features of an excellent midwife’s practice, these alone are not enough to make a midwife excellent. This provides me with a detailed understanding of Heather’s perspective.
The clusters of thematic statements identified in each woman’s individual texts are then grouped together into similar themes found amongst the members of their own group discussion and thematic statements that differ or contradict within that group also noted (Appendix E). This results in an iterative process, considering the women’s texts individually and then as part of the group as a whole. This process continues moving out to look across all three groups, and back again to individual groups and individuals within those groups (Appendix D). This represents the hermeneutic circle, a process of constantly moving from the level of the individual to the whole and back again to consider each statement in light of new understandings.

Once participants identify that they have come to the end of their discussion a summary of the key features within each group is circulated to check with participants that it concurs with their own understanding. These are then added to the overall themes. In this way similar thematic statements are brought together to represent a total of 11 key themes representing the women’s individual, group and eventually the multiple group perspective. This approach allows for any distinctive differences amongst individuals and groups to be recognised. Further detailed exploration of each of the 11 key themes led on to development of 3 major themes (Appendix E). In the next chapter I explore each of these 11 key themes in greater detail and then go on to describe how these merge to form the 3 major themes which represent the significant dimensions of individual excellence.
5 Research Findings

5.1 Key themes in the meaning of an excellent midwife

The findings presented in this section are taken from the written, email discussions of 12 women who participated in three e-groups in 2005/6, to explore the meaning of an excellent midwife. The women involved used their own experiences of pregnancy and birth and their encounters with midwives and other women during that time, to ‘speak’, often passionately, about the meaning of an excellent midwife from their own perspective. The following is a representation of these women’s thoughts, ideas and perspectives, blended with my own through a process of interpretation. The quotations used throughout are the women’s, and they speak for themselves, and although the subsequent meanings inscribed to their words are mine, my intention is that a strong sense of the women’s experience and of their contribution remains evident. For this reason, extracts of the women’s discussions are also represented in the format sent by women, without correction of spelling, punctuation and grammar.

The women were asked to discuss their understanding of the meaning of an excellent midwife and everyone taking part was able to identify at least one midwife within their own experience, whom they felt exemplified this concept. However, it is clear from their discussions that they also found describing the meaning of excellent difficult as an abstract concept. Although they could all identify midwives whom they considered were excellent, they found it more difficult to explain why they thought this and exactly what it was about those midwives that constituted excellence.
As a way of placing their meaning in context, the women often resorted to describing their own perspective using diametrically opposed descriptions. This means that sometimes the women focused on describing what they felt was excellent about a particular midwife, while at other times, they described midwives whom they considered their exact opposite. In this way they were able to use the contrasting images to emphasise the differences that typified their understanding of the meaning of an excellent midwife. This is interesting in research terms because it presents a wider dimension than might otherwise have been considered and provides more detail about behaviours that midwives should avoid as well as those to which they should aspire. In effect, it means that the women were discussing not only their understanding of what an excellent midwife is, but also what an excellent midwife is not.

5.1.1 Theme 1 – Character and Personality

The women's descriptions of excellent midwives feature a number of desirable personal attributes or virtues of excellent midwives who are described as approachable, truthful, friendly, compassionate, polite and sincere. Like other studies which have focused on the qualities of individual practitioners themselves, in midwifery (Hicks 1995, Kennedy 2000, Nicholls and Webb 2006, Reiger and Lane 2009) and other health professions (Kendall 1999, Courtney 2005, Brady 2009) they are also expected to be self aware, non-judgemental and level-headed. However, the overall opinion was that excellent midwives possessed something more than this, as Sophie describes when she says that it’s not ‘just about skills’
‘the midwife should have the skills to do their job but excellence is more than this and I don’t think it’s just about skills.’

Sophie Group 1

The main focus of the women’s discussions, particularly in group 2, is concerned with the character and personality traits of the midwife as an individual, as shown in Kate and Heather’s descriptions:

‘It comes down to the individual and their personality. One person could be great at the practical duty but completely rubbish at interpersonal relationships.’

Kate Group 2

‘The other point is the midwife themselves. It is obvious it varies from person to person and that begs the question is it training or the person’s character. Is it nurture or nature? On going development is always good but for some people we could train them forever and they may just never get it right…..I think for some people caring, listening and intuition comes naturally before skill and competence and that is what counts’

Heather Group 2

The essence of excellence was considered to be a complex phenomenon, consisting of a mixture of skills, attributes and virtues which were specific to the midwife as an individual, rather than to any professional training or education. Heather’s suggestion, supported by many of the other women, was not that professional and practical skill and competence did not matter, but rather that these types of cognitive and motor skills were considered something that could be
developed through training. In contrast, those attributes associated with being caring and to listening and understanding women, were considered to be deeply rooted in the ‘being’ or personal character of the individual midwife themselves. Although the women understood that some development in these personal attributes might occur after the individual became a midwife, such as through ongoing training as mentioned above, the overall belief seemed to be that this concept of an ‘innate state of being’ orientated towards women and to caring, represented a foundational element within the meaning of an excellent midwife.

The personal character or personality of the midwife as experienced by the woman for whom she is caring, is seen as exerting a powerful influence, particularly in making and maintaining good relationships and this could have positive or negative effects on how a woman relates to her midwife. The women’s discussions recognised how there might be difficulties for women and midwives in forging close relationships due to personality clashes between them, as shown in Susan and Hazel’s comments:

‘I think personality will definitely be a factor in the relationship between a midwife and the woman she is treating. Some people clash and this could be difficult to resolve’

Susan Group 2

‘some ladies & midwives clash & they just don’t get a trusting relationship going. i was lucky enough to have a really good relationship with my midwife but one of my pregnant friends who shared the same midwife had a totally different view on her! she found her disorganised & very arrogant, but my friend has been known to get on her high horse & she doesn’t take advice kindly no matter how well intentioned it is. But she got reassigned a
Hazel’s description is particularly interesting because it provides us with two very conflicting views of her midwife. Although Hazel developed a very good relationship with her midwife whom she described as excellent, her friend considered the same midwife ‘disorganised’ and ‘arrogant’. Hazel attributes this to her friend’s personality, rather than the midwife’s, but it does suggest that personality and personal approaches can in themselves have a significant impact on how women view their midwife. It also emphasises one of the reasons why excellence may be so difficult to define, as the meaning of excellent can vary according to the individuals’ perspective and expectations in just the way that Hazel and her friend demonstrate.

5.1.2 Theme 2 – Belief in the specialness of birth

For the women in this study, a key feature of an excellent midwife is her ability to maintain the specialness of birth in the everyday. Karen’s description suggests that she feels this may not be the reality for many midwife practitioners, whose perspective of birth is related to something commonplace and mundane, their daily ‘bread and butter’. This is a perspective somewhat at odds with the woman’s experience. Karen’s words, that midwives and women ‘see’ birth with ‘very different eyes’ suggests that she feels the ability to see birth from the woman’s
perspective and to attempt to step into her shoes and consider things through her eyes, is a hallmark of an excellent midwife:

‘A midwife sees tens of births a year – possibly hundreds in her career. Pregnancy and birth and the post natal period are her bread and butter. I think that it’s often forgotten that this could be the woman’s only experience of it – or an experience that isn’t likely to be repeated more than once or twice. The two look at it with very different eyes: (for) the pregnant woman this is something unique and wonderful, possibly scary and daunting, but a time when she feels special. The midwife sees yet another pregnant woman asking the same old questions, and forgets the specialness or the feelings that go along with being pregnant and having a child.’

Karen group 2

For the women in this study, excellent midwives are those who show real passion and belief in birth, and through this are able to appreciate the uniqueness of each woman and each birth. Maintaining this disposition towards birth as something new and exceptional is also considered to be an intrinsic feature of excellent midwives with Heather suggesting that excellent midwives may be motivated by a vocation, seeing it as something to which they are called, rather than just a job.

‘Does it come down to vocation or just another job’.

Heather Group 2

Excellent midwives are also often described as seeming to love what they do, and this is linked with the concept of vocation. It is considered essential that midwives
maintain a belief in women and in the natural power of birth while still being mindful of the more medically orientated aspects of birth as described by Tania:

‘An excellent midwife is truly 'with women’. She believes in natural birth and a women's ability to birth with her whole being. But at the same time is ability to identify early warning signs of potential problems and work with the women to prevent such problems. She can be supportive and guiding, or totally hands off depending on the needs of the labouring women. At no point does she say anything that would make the women doubt her natural abilities. An excellent midwife truly can go with the flow and appreciate the individuality of birth. She encourages the women and praises her strength’.

Tania Group 3

The ability to successfully merge two potentially contradictory approaches, without sacrificing their focus on women as individuals, is shown in Tania’s comments and many of the other women agreed that this helped them to feel secure, in the knowledge that the midwife would act appropriately to ensure their safety throughout the birth but would not intervene unless necessary. Tania emphasises how the excellent midwife uses her belief in birth and women to ‘appreciate the individuality of birth’ and to encourage and praise the woman. This is in stark contrast to Karen’s description of her experience with a midwife during a friend’s home birth:

‘I find it very hard to think about the meaning of excellent midwifery without thinking about some very poor examples I've heard of or witnessed. They seem to be tied in with this forgetting that it’s a really special thing that a
woman is going through, and something she will remember for the rest of her life. I was at a (home) birth recently with this absolute witch of a midwife who failed to communicate clearly and all trust broke down between her and the couple. It really struck me that even after the baby was born, and all was well, she wasn’t able to congratulate the new parents, comment on how well she’d done, or anything. This was a first-time mum who’d had a home water birth IN SPITE of the nastiness of the midwife, and all the midwife could do was mutter to me in the hallway ‘if she’d been in hospital we’d have given her an episiotomy and got the baby out 10 minutes sooner.’

Karen Group 2

Karen describes the midwife as being unable to congratulate the new parents, showing her feeling that the midwife concerned had lost her focus of belief in the specialness of birth and in the strength and power of this woman. In Karen’s view the behaviour of the midwife towards the parents shows that she no longer appreciates the importance of this event for this woman and her family.

Maintaining a strong belief in birth and in women is therefore very important, however, Nadine is clear that care must not only be woman-centred but also led by the woman and she provides a cartoon to emphasise her point:
Nadine’s point would seem to be that a strong belief in birth is not in itself an indicator of excellence if it is not also associated with the ability to see birth from the perspective of the woman as an individual and to be guided by her wishes. Therefore, a strong belief in normal birth has to be tempered with a focus on the woman as an individual and excellent midwives, while supporting women and promoting normal birth, maintain that focus and are ultimately guided by what the woman feels is right for her. Therefore excellent midwives are able to combine a focus on the woman’s perspective, to recognise the uniqueness of each woman’s experience and to sustain a belief in women and in birth.

5.1.3 Theme 3 - Respect, Trust and Value

The theme of respect, trust and value, is a significant feature of all the women’s discussions with agreement that a feeling of respect between themselves and their
midwife contributed to a trusting relationship which made them feel valued as an individual. The feeling of ‘being respected’ is described in a range of examples involving ways in which midwives related to them, shared information and supported their decisions.

‘Sharing the test results breaks down that feeling that they know everything about you but you know very little’

Nina Group 1

‘At every antenatal Eve (the midwife) would explain exactly what she was doing and why. She would never presume that I wanted the ‘normal’ tests but would provide me with unbiased information and respect my decision, only offering her own opinion if asked. ……at no point did she presume to know what was best for me’

Susan group 2

Susan appreciated the way that Eve was able to provide information and advice but did not pre-judge her potential choices or course of action. Even though Eve, as the midwifery professional, might have been assumed to know ‘what is best’ she refrained from offering her own opinion except when solicited, so that Susan felt free to make her own choice without recourse to what was expected of her by others. This meant that Susan felt her opinion mattered to Eve, and through this she felt valued.

Although the rhetoric encourages women to make choices which are specific and suited to them individually, in just the way that Susan did, the reality of informed
choice would often seem to be somewhat different as shown in these extracts from Vicky, Hazel and Tania:

‘I believe a woman has the right to have things explained clearly (which I accept is not easy in terms of complex problems), and to have the appropriate care - including any downsides - laid out before a final decision is taken (apart from in emergency situations).

Vicky Group 1

‘Ladies should have more choice & be more fully informed of procedures during pregnancy & Labour. A point i would like to emphasise is tests run on the baby for illness etc. I was asked beforehand whether i wished to have the tests run & just what they were testing for but a lot of women i have spoken to don’t even know what their blood has been taken for! I think some women generally think that the midwife said ‘this needs testing for’ & stick out their arm for blood to be taken.’

Hazel Group 2

‘In fact it is legally true that all care decisions are up to the women, however, women often feel they do not have this control. Putting women in control of decisions helps to make them feel responsible and in control of their health and for their birth’

Tania Group 3
Within the group discussions there is a general feeling that information giving and the concept of informed choice is something which is often merely paid ‘lip service’. There is also a recognition that many women are unaware of their choices and options and that this can therefore make truly informed choice very difficult for women. Given these concerns, the way in which their own excellent midwives are able to provide information, and support their choices, appears all the more exceptional in the women’s eyes.

The value attached by women to the concept of respect for women is shown in Susan’s description, where she uses an example of language used in a disrespectful way to emphasise the importance of respecting the woman and being guided by her values and wishes:

‘What’s fundamental is that the midwife respect the woman and be guided by her values and wishes as far as possible. And also that they are not rude! This may sound obvious but I know of one young mum (18, the father of the baby was her boyfriend of 2 years) who was told to “stop making such a fuss” during labour, because if she’d kept her legs shut she wouldn’t be in this pain!’

Susan Group 2

The midwife’s lack of respect for the woman in Susan’s description is clearly shown by her use of such cruel and degrading language. While this was an extreme example within the descriptions, many of the women cited other examples of how midwives used language and behaviours towards them which made them feel unimportant, silly or stupid.
Kate’s comment builds on this when she suggests that the way in which women are treated by midwives is a key denominator in how women view their midwife. In her view, it is not the doing parts of midwifery that make the difference, but the ‘being’ elements as described by Walsh (2006), specifically those that show respect for women as individuals.

‘I think we all agree that it not necessarily what the midwives did for us it’s what they said, how they treated us and how they interpreted our needs’.

Kate Group 2

Another feature linked with feelings of respect and value was the women’s emphasis on how important it is to be ‘heard’ and how excellent midwives demonstrate the ability to not only transmit information but also to listen and through this understand what is important to women:

‘The midwives I came into contact with listened & understood the exact type of birth I wanted and seemed just as keen to help me achieve it’

Hazel Group 2

Listening skills, particularly active listening, were mentioned frequently and the women were well aware of the differences between passive and active listening. Listening in this context also involves understanding and is a key element in establishing trust between midwife and woman. Women wanted midwives to really listen to what they were saying, and to understand on a very deep level what is important to them as individuals. Inherent within this is the women’s feelings that not only do the midwives hear what women say to them, but also that they believe
and value what the women tell them, and in turn encourage the women to have belief in themselves.

For these women being listened to means that their midwife has really understood what is important to them, thus creating a dual trust dynamic, with women trusting the midwife to know what to do and the midwife trusting the woman to do the same. Karen explained how this trust dynamic had contributed to her positive experiences of birth:

‘I had an independent midwife, and what was excellent about her was she listened very well to me without judging and by the time labour arrived she had totally sussed me out, what was important, what wasn’t and I trusted her totally’.

Karen Group 2

As well as highly developed listening skills, other forms of communication were key to making women feel trusted and valued as an individual. Excellent midwives are described as demonstrating a range of specific skills in this area, enabling women to ask questions, seek information, discuss issues and ideas and being made to feel special, individual and respected. The excellent midwives are seen as open, non-judgemental and giving, offering their time, knowledge and experience to enable women to become joint decision makers and to provide much needed reassurance as demonstrated by Kate and Tania:

‘My excellent experience was a young midwife, who was on a night shift. She came into the room at 10pm. She told me what was going on with the hormone drip, what the monitor was for, she read my (birth) plan, answered
my questions no matter how stupid, suggested ways to help myself, really reassured me. She responded as soon as she thought something was wrong and held my hand during my epidural before I went to theatre. I think the overall thing here is that she gave me her time and her knowledge and reassured me during a very scary experience’

Kate Group 2

‘She always took time to explain everything, and to give me time to ask questions, no matter how busy’

Tania Group 3

Finally, trust between the midwife and woman is seen to be important elements in helping women maintain a feeling of control and promoting confidence in their ability to manage labour and birth. This link between trust and confidence was mentioned by many of the women and was also seen as important in helping women to feel safe, reducing the ‘scariness’ of the situation as mentioned by Susan:

‘Feeling trusted by our midwives increases our confidence and helps us to feel in control of our labour…… if women feel confident and are encouraged to trust their instincts and their bodies then the scariness of the situation is minimised and a better outcome likely.’

Susan Group 2
‘The best little example is when I called her to tell her I thought ‘this was it. She just said, ‘lovely, that’s great, I’ll see you in about 3/4 hour’. It made me feel confident and TRUSTED. That really contrasted with my other two (NHS hospital birth and NHS homebirth). You phone to say you’re in labour and it’s like they don’t believe you They don’t care how you FEEL... it’s just ‘how far apart are the contractions, blah blah blah.’ You’re talking to a stranger and they’re TESTING you. I took that approach for granted until I had the experience with my IM (independent midwife). She knew I needed her, so she came. End of story’

Karen Group 2

That trust is something that may take time to build up to, for women and for midwives, is also evident in Karen’s description above. Karen’s feelings of being ‘tested’ by the unknown midwife, to use her own words, a stranger, during her previous experiences and of not being trusted to know what was happening to her own body when she phoned to say she was in labour, emphasise how knowing your midwife may have significant benefits for women.

However, not all of the women felt that getting to know the midwife was key to feeling respected, trusted and valued, as also noted by Fleming (1998). What seems much more important is the way in which the relationship is formed and maintained. Some of the women who describe excellent midwives only met their midwife for the first time during their labour, as shown in Kate’s description of an excellent midwife. This suggests that these excellent midwives are able to develop a respectful and trusting relationship in a very short time, and this is linked to the way in which they treat women with a caring, respectful and individualised approach.
5.1.4  Theme 4 - Equal but different

The theme of equal but different relates to the way in which midwives and women view the context of their relationship with midwives. As Hyde and Roche-Reid (2004) found midwives retain a certain degree of power over women relative to their expert knowledge and for this reason Leap (2000) asserts that the relationship between the woman and midwife can never really be thought of as a partnership in the traditional sense. However, as Nadine suggests:

‘I believe the difference between midwifery and medicine lies mainly in the midwifery model of working ‘with’ a pt, rather than doing to a pt, a relationship of equality, not hierarchy’

Nadine Group 3

Nadine’s view of the midwife, working in a relationship of equality rather than hierarchy, is at the heart of modern midwifery models of care and the majority of the women across all three groups mention how important it is that their excellent midwife treated them as an individual, tailoring care to be specific to them and making sure that they were consulted before decisions were made.

‘With Eve (midwife) it was wonderful to know that I would be consulted on every aspect of my pregnancy and labour. All women are individuals, we have different body shapes, different values and opinions and different pain thresholds! It is ridiculous to assume that what is best for one woman is also right for another.’  

Susan Group 2
Working in such a valued relationship, with the midwife providing information and support but the woman feeling that she maintained control in decision making, was cited as key to this feeling. So in this context when women talk of equality they are not meaning ‘equal’ in the traditional sense, but rather that each brings something unique to the relationship, the midwife contributes her professional knowledge and experience while the woman brings her personal knowledge and her own life experiences (Pairman 2000), hence the concept of ‘equal but different’. There is a suggestion that excellent midwives recognition of this concept ensures they approach each woman as an individual and are therefore able to tailor care to suit her specific needs. Sophie’s comment highlights how this individuality extends even into the kind of relationship a woman has with her midwife:

‘Fundamentally though, I believe it’s about forming a relationship the woman wants’

Sophie Group 1

The concept of ‘equal but different’ may also help excellent midwives deal with potential conflict arising within their relationship with individual women when women’s wishes are contrary to what the midwife believes is right or safe. Nadine noted that this might be quite a problem for them:

‘The difficulty comes in when the pt’s needs conflict with what the midwife feels to be safe and evidence based; if a medically unstable pt wishes to birth at home and the MW feels that this is an unsafe environment for the woman in question, what is the ’excellent' MW to do? Should s/he focus on harm reduction and attend the birth anyway? Should she try to convince the
woman to deliver in hospital? but how does a MW respect a pt's autonomy when the pt wishes to do something 'dangerous'?

Nadine Group 3

Nadine appreciated this is a significant dilemma for the midwife and recognised that in some instances professional responsibility or personal beliefs might be at odds with a midwife’s desire to support a women’s needs. This is an area of practice that midwives may often struggle with, and it also represents an area in which opinions on what constitutes an excellent midwife may vary considerably, depending on the viewpoint.

For most of these women, continued support from the midwife is important, even if the woman’s decisions are at odds with professional advice. This is represented by the women’s belief that they should ultimately make decisions for themselves. Although the midwife should ensure that they provide support and advice, the final decision must be the woman’s. In this case, ‘equal but different’, could mean that the midwife would choose to support the woman’s rights to make her own decisions, while the woman would have to reciprocate by understanding the midwife’s contrary position.

‘In this sort of situation, as long as all benefits and risks have been explained clearly and without bias then it may have to be accepted that some women are not willing to listen if the information presented is likely to shatter their dreams of the perfect labour.’

Susan Group 2
However, it is interesting to note that although the majority of the women, like Susan, felt that women should have choice and the power to choose for themselves, they also concede that some women choose what others might consider foolish or dangerous. In this situation, excellent midwives can only offer information and support and have to work out a way of accepting the woman’s viewpoint without compromising their own beliefs.

5.1.5 Theme 5 - Controlling or Supporting

The theme of ‘controlling or supporting’ relates to the women’s discussions about how they see midwives as acting in ways which control women or support them. Some midwives are described as using their position of authority, as the professional or ‘expert’, to control women’s behaviour and choices. These observations, offered as a counterpoint to the descriptions of excellent midwives, are used by the women to illustrate the difference between the midwives seen as excellent and others in their experience.

While many of the women identified covert feelings of coercion, of pressure to conform, some emphasise more specific ways in which midwives create control within the relationship, using behaviours like withholding information, belittling women’s concerns and using their position of greater knowledge to make women feel inferior:

‘To be dismissed offhandedly puts you in a position of being the silly little girl facing up to the ‘expert’.

Karen Group 2
Not all midwives appreciate being questioned and feel they aren’t obliged to divulge information sometimes’

Heather Group 2

It is interesting how Heather represents some midwives as resistant to challenge in the form of questions, a position which Heather sees as the midwife deciding exactly what and how much the woman needs to know. This is similar to Karen’s feeling that the midwife uses her position of relative power, as the expert who knows everything, to maintain a position of authority, a position of power over. Tania’s comments also show her understanding of this position, although in this case, the midwife is not withholding information but using knowledge as a way of achieving control through fear:

‘They tell women what they are 'allowed' to do, instead of providing information to the women and allowing for the women to have true 'informed choice'. They say things like ‘you are risking your babies life’ if you do such and such, without any evidence to back up the statement’

Tania Group 3

This is contrasted with the professional behaviour of the midwives described as excellent who were considered to be open to questioning and to challenge from the women, perhaps suggesting that these midwives felt comfortable with their own professional knowledge and with their own view of their professional role as information giver rather than information controller.

Two of the women are much more direct about their experience of control by midwives, Susan citing the use of cruel and degrading language as mentioned earlier and Hazel (below) talking about control through the use of medication:
‘Sometimes, the feeling of having pain relief pushed in your face makes you think they just want to drug you up so that you are quieter or easier to handle in labour and won’t argue about what position ‘they’ put ‘you’ in’

Hazel Group 2

Hazel’s words indicate her feeling that midwives used the offer of medication as a form of control mechanism to ensure that she was more compliant and would follow the preferences of the midwives during the labour, rather than her own. It is interesting that she has interpreted this as a controlling function, rather than a caring one, as the midwives trying to offer her relief for pain might be seen as a more caring action in some situations. Perhaps the big difference is not the offer, but the way in which it is offered. Hazel’s use of the words ‘pushed in your face’, suggest that the feeling of control is more related to the midwife’s failure to understand Hazel, and to see that what she was offering was not what Hazel wanted.

The women seem to be very influenced by the social norms of professional versus patient, often making reference to ways in which they feel the ‘professional’ aspect of midwifery is used to reinforce the gulf of knowledge and standing between the woman and the midwife (Hyde and Roche-Reid 2004). The texts often make use of words that signify a perception of the midwife as more knowledgeable and powerful than the woman. For example, Kate considers her midwife is excellent, and part of this is related as her statement that the midwife,

‘answered my questions no matter how stupid’.

Kate Group 2
This would give the impression that Kate feels her concerns and worries, and hence her questions, are of little value from the perspective of the midwife and that, in answering these trivial questions, the midwife is being especially patient.

What is also interesting is the way Tania points to the powerful influence of the midwife during birth when she stipulates that the midwife,

‘should not say anything to make the woman doubt her natural abilities’.

Tania Group 3

How midwives speak to women and the way in which they say things is also mentioned by several women in this study, as in others (Hunter 2006b, Furber and Thomson 2010). Excellent midwives are therefore fully cognizant of the relative power imbalances within the midwife and woman relationship and know that the type of words they use and the way in which they say them can significantly affect the woman’s conceptions of herself and her abilities to cope with events during birth (Fahy and Parratt 2006, Furber and Thomson 2010).

Speaking to women in dominant or disrespectful ways can also impact on how women deal with situations which are outside their sphere of expectation and therefore, depending on how they view their own part alongside that of their carer, whether the event is seen as negative or positive outcome. Women who feel that they have been in an ‘out of control’ of situation in labour are significantly more likely to feel their experience was a negative one, especially if it doesn’t fit with their own preconceptions of what they were expecting (Hauck et al. 2007), as suggested by Tania:
‘All women should make their own decisions about medical procedures with true informed consent. This gives women a sense of control. Control can make it much more easy for a women to deal with a traumatic situation, without long lasting psychological consequences’

Tania Group 3

Tania’s suggestion would seem to be that maintaining a sense of control will help the woman come to terms with unforeseen or traumatic events during her labour. Although events may occur that are outside the woman’s sphere of influence, the ability to make decisions during that time, to be actively rather than passively involved and thereby maintain a degree of control over some part of events, can go some way towards helping them come to terms with events.

However, supporting women and ensuring that they are able to maintain a feeling of control in their care is also complicated by more systemic issues. Susan’s comment draws attention to the power of the institution and to the socially embedded power of the healthcare system itself:

‘We waited until we were called and followed a woman into a room where she told me to take off my shoes and get up on the bed. Next to me was ultrasound equipment and she immediately told me to lift my top so that she could begin the scan. What scan?! Nothing had been said to me about this and yet I felt completely obliged to comply.’

Susan Group 2

Susan’s experience of an ultrasound scan is revealing because it highlights the effect of subconsciously dominant relationships on women’s behaviour and choice. That Susan, a woman comfortable in asking questions, making her own decisions and who chose not only a homebirth but an independent midwife, ‘felt completely
obligated to comply’ in this situation, contributes to an understanding of how the intrinsic power of the institution can affect women and the choices they feel able to make.

For some women however, a supportive relationship with their midwife in which they were fully aware of available choices and were able to choose what was best for themselves, contributed to increased feelings of confidence and empowerment:

‘Those who display 'excellence’ to my mind are those at every level, who give me confidence.’

Nina Group 1

‘The birth of my daughter was the most empowering experience of my life. I now have a personal mission to make women more aware of their birth choices and the fact that they can be in control of birth related decisions.’

Tania Group 3

5.1.6 Theme 6 - The real versus ideal world

The theme of ‘real versus ideal world’ describes the ways in which women understand the reality of maternity care. This also includes the recognition that midwives are often struggling to work in a system with many constraints upon them. All the women in all three groups, without exception, expressed an understanding of the contradictions between how they felt things should be and how things actually are, using the words ‘ideal’ or ‘perfect’ and ‘real’ alongside world as shown below:
'In the perfect world, one would expect to be able to obtain access to whatever you choose ...... without being told one lives in the wrong part of the country!'

Vicky Group 1

‘I think in an ideal world, I’m asking midwives to put the woman’s needs before their own. Note ‘ideal world’, of course this doesn’t happen often. But when you meet midwives who do that - who make us feel really special and listened to – you realise what the gold standard of maternity care is’

Karen Group 2

Karen’s comment specifically emphasis’s her feelings about how rare it is to find excellent midwives, those who make women feel ‘really special and listened to’ and for her, this is a real world perspective reflecting the current reality of maternity in the UK rather than her ‘ideal world’ view that all women should have ‘gold standard’ care. Other women, especially those in group 2, considered reasons why many midwives were far removed from this gold standard:

‘This last comment really made me think about why some midwives can seem so impatient or offhand when dealing with a women’s worries and concerns? My guess is that it’s because they hear the same concerns from women every day in their jobs.’

Susan Group 2
Recognition that midwives might feel conflict between what their beliefs tell them and what is actually viable within real situations means that women see this as a significant dilemma for midwives. As Vicky suggests, lack of resources might make it very difficult for midwives to support the kinds of choices that women want:

‘it may be that the NHS does not currently have sufficient budget to fulfil expectations.’  

Vicky Group 1

Most of the women are of the opinion that midwives are overworked, looking after too many women at one time and might also have limited options, however, this should not affect the way the midwife interacts with the woman. Excellent midwives are often cited as being able to maintain an unhurried approach and availability for women despite these constraints:

‘they never seem too busy to spend that extra bit of time being friendly and informative (even if their job seems never ending)’  

Hazel Group 2

Spending time and providing an unhurried approach is shown as important to Hazel, and this is also evident in many of the other women’s comments and is seen as one of the exceptional qualities of excellent midwives. The women’s discussions show that they are only too well aware of the differences between the real and ideal world of maternity care and therefore, their midwives ability to provide them with care that they consider ideal, epitomises what is different about these midwives.

Many of the women also stated their feeling that they were lucky, perhaps emphasising this understanding that reality is very different for many other women.
‘I too find it hard to believe many of my friends horror stories of their hospital labours and feel incredibly lucky to have received the wonderful care I did’

Susan Group 2.

‘I was lucky to have a wonderful birth experience with a fabulous midwife, but I am all too aware that my birth experience could have been very different because it did not follow conventional ‘norms’.

Tania Group 3

The women’s use of the word ‘lucky’ is striking, and provides insight into the women’s view of current maternity services and of midwives in the UK. Although the women have very specific ideas about what the level of maternity care should be, they are well aware of the dichotomy between real and ideal worlds. Excellent midwives are seen as rare and unusual and this means that women feel they have been particularly lucky if they are cared for by someone who supports them in a way they only hope to expect.

5.1.7 Theme 7 - Making Allowances

Making allowances is a theme related to undesirable behaviour in midwives and to the women’s understanding of why they may act in this way. Many of the women
talk about behaviours of midwives which they find unacceptable and these are used as a way to illustrate the difference between these behaviours and their own excellent midwives. Making allowances for poor practice behaviours represents the belief that these women have that the majority of midwives are intrinsically good (de Raeve 2002) and that bad behaviours, such as being inpatient or off-hand with women, are largely due to influences outside of the control of the midwife. The most frequently cited excuses are those of workload pressures as suggested by Hazel, and constraints imposed by a medical model of maternity care as suggested by Susan:

‘I also agree with Heather that midwives do have a huge case load & the pressure must be unbearable at times but some people work better under pressure, although I do feel sometimes there’s so much expected of midwives that it would put me off ever picking the job’

Hazel Group 2

‘I also hold a very strong view that often the problem lies not in the individual midwives but in the hospital policies… If the midwife tries to argue then they are told over and over that they need the bed and can’t have women in this long. It’s no good training excellent midwives if they are then not allowed to their job properly because of politics.’

Susan Group 2

These views show that the women are aware that midwives working in the NHS in the UK may be subject to a significant amount of extrinsic control of their practice,
and that they might therefore, be constrained and unable to act as they would wish:

‘I think if any of the midwives involved with me knew how I felt about my experience I’m sure they would be disappointed.’

Kate Group 2

Kate’s comment reflects her belief that the midwives who failed to provide the support that she required during her pregnancy and labour are not considered uncaring, simply unable to provide the kind of care they would wish due to constraints within their practice environment. During her birth the midwives were busy and Kate was left alone for long periods with little explanation, feeling anxious and frightened. Although this has had a significant negative impact on Kate’s experience of birth, her comment suggests that she believes the midwives intentions were good but that their actions were lacking, perhaps due to workload pressures. Midwives are expected to be care about women in a personal and psychological way, not just care for them in the physical sense.

Karen suggests another reason why midwives may not act according to the wishes of the woman or who may have difficulty in supporting women, particularly during birth:

‘Midwives who are not properly debriefed of their own experiences, who can’t stand to see people in pain so urge towards epidurals. Comments about labouring women making ‘too much noise’ so they’re given pethidine to shut them up’

Karen Group 2

These features, potentially constraining and shaping midwives behaviours towards women, are offered as explanations for why some midwives are not as caring as
women would expect. Midwives working within the system of the NHS are considered to be under considerable constraints; however, those midwives described as excellent are still able to maintain caring and supportive behaviours towards women, despite these constraints. This marks them out as different to other midwives, giving them something special and unusual.

5.1.8 Theme 8 – Expectations of the Professional Role

This theme relates to how the women viewed the professional role of the midwife and the fit between how midwives act and the women’s socially constructed ideas of what a midwife should be. In trying to define excellent midwives, the women identify some behaviour that falls outside their own conception of the professional midwife role as shown in this comment from Hazel:

‘People asked me if my midwives were private after my labour because they actually cleaned my bedroom up, stayed for a cuppa and even posed for photographs with my daughter. They couldn’t have been nicer but deadly professional when the time was upon us’

Hazel Group 2

Hazel, suggests a perception that the professionals undertaking mundane and personal tasks, such as cleaning, posing for photographs, staying for a cup of tea and being nice, are attributes not expected of a professional midwife, perhaps therefore, feeling the need to state they were ‘deadly professional when the time came’. Her use of the words ‘actually’ and ‘even’ show that she considers it unusual for the midwives to behave in this way, perhaps highlighting an understanding of the professional role as inconsistent with these mundane caring
activities. The fact that others also consider this behaviour unusual by suggesting that the midwives might be private because of their extended care activities, may also highlight a more general perception of midwives as more orientated to the professional aspects of the role than caring ones.

This is also reflected in a comment from Heather who draws attention to the apparent dichotomy between a professional role and a caring one, giving the impression that there can be an either/or position between skill and competence in contrast to caring, listening and intuition:

‘how do we get midwives with skill and competence and able to be caring, listen and intuitive’

Heather Group 2

One of the features of excellent midwives which appear frequently in the group discussions is a feeling that excellence is related to a midwife’s ability to blend seemingly incompatible elements together, to offer care which is both professional and caring. Excellent midwives ‘stand out’ because they seem to willingly undertake tasks which the women consider menial, and which they do not consider part of the professional midwife’s role, perhaps giving the impression that these midwives were doing something extra that they don’t have to. These small tasks, usually associated with physical caring, but also sometimes including psychological support, are described by the women as ‘the little things’ that midwives do, a phrase also used by nurses in Pearcey’s (2010) study of caring in nursing practice. Women seem to consider that their midwives are being especially kind, patient or supportive in performing these small acts of care as seen in Hazel’s comment below:
‘It was the little things that made me feel better, like when there was meconium in my waters my midwife explained to me 3 times what course of action he was taking, why he was taking it and if I agreed, he also rubbed my back between contractions, assuring me I was doing well while I moaned like an animal. Sometimes small things make the whole difference as to how you view your midwife when your in labour!’

Hazel Group 2

5.1.9 Theme 9 - Theoretical Knowing

This theme relates to how midwives evidence their professional theoretical knowledge. Provision of accurate, up-to-date and useful information, pitched at a level appropriate to the individual, is a feature within all the women’s discussions. Excellent midwives are seen as one of the main sources of information for women and as such, are considered to require a detailed and current knowledge base and a willingness to share this information to help support women’s informed decision making and choices. The women are clear that this is considered a great responsibility and midwives should be able to offer a range of advice appropriate to individual women in an ‘honest’ and ‘straight forward’ way.

They should be knowledgeable ….. and offer advice which is honest, appropriate and straight forward.’

Nina Group 1
Provision of information in this honest or unbiased manner is of vital importance because the aim of excellent midwives is to support women while they make decisions that are relevant and applicable to their own circumstances. Susan for example, appreciates the way that her midwife Eve offers information without presumption or opinion so that she is able to choose the best course of action for herself from a full range of options, not simply those considered usual or normal:

‘At every antenatal Eve would explain exactly what she was doing and why. She would never presume that I wanted the ‘normal’ tests but would provide me with unbiased information and respect my decision, only offering her own opinion if asked.’

Susan Group 2

However, getting the balance right can be difficult and in some cases, women feel that midwives focus too much on research evidence, bombarding women with information which only serves to emphasise the knowledge gap between them, and often seen as to the detriment of the more practical skills required of a midwife:

‘Regarding research....sometimes too much information can be a negative thing. Proper basic care should be the first approach’

Kate Group 2
‘It (excellent midwifery) means encouraging women to make healthy choices without insisting that women be passive recipients of the midwives great knowledge and advice’

Nadine Group 3

From Kate and Nadine’s comments it is apparent, that while women want excellent midwives to have a substantial and up to date knowledge base and the willingness to share this with the women they care for, this type of theoretical knowledge is not in itself enough. Indeed, midwives who focus too specifically on their ‘expert’ status through the overuse of theoretically based knowledge are in danger of discouraging or alienating women by emphasising the knowledge gap between them. In contrast, excellent midwives are able to accurately judge the needs of individual women, offer them information appropriate to those needs and ensure that women feel they are able to choose the best course of action for themselves. Moreover, expert advice has to be balanced with the physical and emotional needs of individual women and presented in a way that is honest, straightforward and accessible.

5.1.10 Theme 10 - Embodied Knowing

This theme is associated with the ways in which women understand the experience of birth and the way in which midwives gain this. It is suggested that personal experience of birth is an important part of any midwife’s experience however, the women’s belief is that this is not always true. While acknowledging
that there is a general perception amongst women that midwives who have given birth themselves bring a deeper level of understanding to the birth experience, the opinion of these women is that it is professional experience that really counts. Kate is very much of the opinion that personal bodily experience within a professional role is not relevant. In her comment below, she asks why midwifery should be so unlike other professions in this regard. In other fields of healthcare and for other healthcare professionals, there is not a general perception that the professional in a specialist field of practice should have had the same bodily experience of health (or ill health) as those they are caring for:

‘I love it when people say how can someone provide ‘care’ if they haven’t experienced it themselves. That’s like saying, for instance, every psychiatric nurse must have suffered a psychiatric problem, or an ICU nurse must have suffered near fatal illness’s. It really does not and should not effect the ‘care’, surely this is what the 3 yr training is for and life long learning is in place for’

Kate Group 2

Susan’s opinion is a little different in that she feels that midwives who have their own bodily experience of birth might bring an ‘extra level of understanding and empathy’ to the relationship. However, she also goes on to say that midwives with personal experience of birth are no more likely to be able to support women during pregnancy, labour and birth than those without, as all women’s expectations and experiences will be different and therefore no one can ever know what it is like for someone else. Indeed, personal experience might actually be detrimental if it leads midwives to assume that they ‘know’ what it is like for another woman:

‘Personal experience is also a hotly debated subject as I have often heard women make the comment that a midwife can’t be great until they have
been through labour themselves. To me this seems unfair. I believe that when they have been through it there may be an extra level of understanding and empathy, but as I keep saying every women experiences labour differently and so no one person, whether they've had a baby themselves or not, can ever assume to know what it's like for some one else’

Susan Group 2

While Susan feels that midwives who have experienced pregnancy and birth might not necessarily bring more to the birth encounter with women, Hazel feels that it might make a difference to the way in which they treat women. Her own midwife’s personal experience of birth led her to train as a midwife:

‘Experience may be a factor as i know 1 of my midwives had experienced bad care themselves hence their change of career in midwifery’

Hazel Group 2

For the women in group 2 particularly, knowledge gained through professional experience of birth is felt to be an important feature of an excellent midwife. Many of the women are reassured by the knowledge that their midwife has professional experience of many births, assuming that they will therefore know how to act in case of any unforeseen emergency. Hazel’s comment emphasises the link between this experiential knowledge of birth and her feeling that this reduced the level of confidence and trust she has in her cousin, a midwife in training:
'My cousin, who’s training, attended my labour and although she was really great, I wouldn’t have been able to put my full trust in her knowing she hadn’t done quite a few births beforehand, my mother would say ‘there’s a first for every midwife’ but I just wouldn’t be happy to be the first I’m afraid.

Hazel group 2

Susan agrees by saying that she feels many women might find it hard to trust a midwife with less professional experience of birth, such as a newly qualified midwife. The knowledge that her own midwife, Eve, had attended many births and is therefore able to deal with any situation that might arise, including any emergencies, means she is able to place a high level of trust in Eve, and to feel safe. However, Susan also acknowledges that attendance at many births is not in itself a guarantee of excellence because in some cases, rather than enhancing the midwifes practice, it might have quite the opposite effect. Midwives exposed to birth ‘every week for years’ might become ‘desensitized’, forgetting the excitement and specialness of birth so while they might have the desired experience of birth, in terms of actual numbers, they would not have learned from this in a positive way and this would detrimentally affect their approach to care. It would seem therefore that although experience of birth, either through professional or personal exposure is important, what you do with that experience and how you use it is what really matters:

‘As far as professional experience goes I think many women would find it hard to trust a newly qualified midwife. I know that I was reassured by the knowledge that Eve had years of experience and had dealt with many different situations, including life or death emergencies. However, I also think that some midwives delivering babies every week for years could
become almost desensitised to what the women are going through and struggle to see each woman and labour as a completely new situation.’

Susan Group 2

Therefore, experiential knowledge of birth while reassuring and important is also a complex issue and represents only one aspect within the meaning of an excellent midwife. It is also essential that midwives have other qualities including those that support their experiential development of knowledge whilst still allowing them to maintain the desired attitude towards women and birth.

5.1.11 Theme 11 - Practical knowing

Practical knowledge is a theme related to the physical care of women and to the physical skills competency of midwives as observed by women during their encounters with midwives. The women’s descriptions of what excellent midwives should demonstrate in terms of practical knowledge are very much related to the doing elements of midwifery practice, and therefore include knowledge related to emergency skills and complex births, as well as everyday care of women during pregnancy, birth and postnatally:

‘An excellent midwife is well trained to handle emergency situations such as, shoulder dystonia, need for resuscitation, maternal haemorrhage, etc. An excellent midwife also is trained and able to attend less traditional births, such as natural vaginal breech birth, and vaginal twin birth.’

Tania Group 3
The word ‘trained’ is used frequently within the women’s discussions with regard to this category, perhaps identifying this type of knowledge with the more traditional or vocational social constructions of the work of midwives. This may also provide an understanding of why this form of knowledge is the one most frequently used by women to judge overall professional competence. While women may use their socially acquired pre-knowledge and their personal observations of midwives practical knowledge to ascertain levels of overall competency, they all find it very difficult to judge individual midwives.

Levels of competence are mostly assessed through superficial measures such as how confident the midwife appears, their general demeanour or other visible features like age. In the same way as theoretical knowledge the women also comment frequently that midwives are often considered to be competent by virtue of their professional registration. At least one of the women, Heather, recognised the potential problems associated with a façade of confidence which might not equate to a true representation of the competence of a particular midwife.

‘within the community I have had a different experience with two community midwives that shared our GP practice. One was confident, very chatty and instilled that in you making it seem that all was ok. The other could only be described as a bit ‘dippy’, quiet and not always looking like she knew what she was doing. However, this midwife, always got it clinically right with my pregnancies and always referred me to the hospital if I had any problems. The other midwife, although confident, did get it wrong on a few occasions. So you can never tell, and we should always look a bit deeper than the chat!’

Heather Group 2
Heather suggests that she initially considered the confident midwife to be more competent than her somewhat ‘dippy’ colleague, however, given time and an alternate measure by which to judge competence, in this case, the correctness of the midwives clinical predictions over time, she soon revised her original opinion.

Heathers comments highlight the problems that women may have in being able to measure performance in areas that are outside the scope of their own personal knowledge and experience, hence the women’s general presumption of knowledge and competence within the professional scope of practice. It also draws attention to the immediate impression a midwife may have on a woman, with women often using very general and superficial measures by which to judge competence. In situations where women have the opportunity to observe their midwife over several occasions, other factors may come into play, as described by Heather, but for many women, first appearances count for a lot.

Many of the women stress how they value the practical knowledge based skills associated with traditional midwifery practice but feel that these skills are being crowded out and devalued by a focus on skills related to the increasing use of medical technology in the birth environment:

‘In fact, in my opinion, one of the problems at the moment is that far too much emphasis is placed on technology in the labour ward, taking away from the skills of the midwife and more and more they are not being allowed to do the job they are trained for ……I’m not saying that medical technology doesn’t have its place but that perhaps there is too much reliance on it at the expense of one to one midwifery care.’

Susan Group 2.
For the women in these discussion groups, the midwife’s job is very much related to being there for women therefore, midwifery-specific practical knowledge, and by this they are referring to the less technical skills associated with traditional midwifery roles, are highly valued. It is interesting to note that although midwives roles in the UK have included the need to become increasingly familiar with the technological aspects of maternity care and, indeed, some midwives themselves value mastery of technical equipment and procedures over and above those of normal midwifery (Pollard 2010), none of the participants featured this as an element of the practical knowledge that they expected excellent midwives to demonstrate. On the contrary, excellent midwives were expected to use midwifery-specific skills articulated as achieving care through quiet observation, minimal intervention and working with woman and it suggests that these women’s perception of midwives as experts differs somewhat from the professional perspective, which tends to place higher value on technological skills.

5.2 Dimensions of excellence

Eleven key themes are identified through the women’s discussions and these can be grouped to form three main concepts which represent dimensions of excellence in midwives. The overarching dimensions focus on the specific skills, knowledge and attributes that are found in midwives whom the women consider excellent; however, these dimensions also have something more to say about excellence as a way of ‘being’. The women’s descriptions of their experiences of birth and of their relationships with midwives draw attention to their understanding that excellent midwives are excellent because of who they are, rather than what they
are. Therefore, as Pellegrino (2007) suggests, it is one thing to ‘have’ the qualification of midwife, it is quite another to ‘be’ a midwife.

What is means to be an excellent midwife, understood from the perspective of the women taking part in the group discussions, can therefore be related to three specific dimensions of ‘being’ an excellent midwife that I have conceptualised as ‘moral being’, ‘relational caring’ and ‘authentic professionalism’ and which combine to form an original view of midwifery excellence. This consists of a way of being within themselves (moral being), a way of being in their relationships of care (relational caring) and a way of being within the role of a professional midwife (authentic professionalism).

‘Moral Being’ combines three themes: ‘character and personality’, ‘belief in the specialness of birth’ and ‘respect, trust and value’, and which represent the midwife’s internal perspective and disposition towards the world and midwifery. ‘Relational Caring’ combines the themes of ‘equal but different’, ‘controlling or supporting’, ‘the real versus ideal world’ and ‘making allowances’ to illustrate excellence as seen within the caring relationships between women and midwives. Finally, ‘Authentic Professionalism’ combines themes which describe the professional knowledge and behaviours expected of excellent midwives, ‘expectations of the professional role’, ‘theoretical knowing’, ‘embodied knowing’ and ‘practical knowing’ (see appendix E). These concepts are discussed in detail in the following chapter.
Discussion of the research findings

6.1 Being, Knowing and Showing Excellence

Analysis of the women’s email conversations, illustrated in the previous chapter suggest that the meaning of an excellent midwife is grounded within the person of the midwife as an individual. This can be conceptualised as a mode of ‘being’, a way of seeing and behaving in the world which provides a moral framework for personal and professional life. Three key dimensions are suggested which combine to create the meaning of an excellent midwife and which are constructed as ‘moral being’ concerned with the person of the midwife as a human being in and of the world, ‘relational caring’, which deals with the midwife as a caring professional and ‘authentic professionalism’, which is concerned with the midwife as a professional carer. An excellent midwife is able to use these dimensions of self, a way of being, knowing and showing, as a framework for guiding her practice, a kind of ‘moral compass’ by which to navigate her daily life as a midwife and through which she views the world and in turn relates to others.

6.2 ‘Moral Being’

The women who participated in this study describe excellent midwives as having a special quality which they believe is attributable to the person of the midwife themselves. This special quality, resting on the inherent personality and character of the individual midwife, is the key feature of those midwives considered excellent and is shown in a way of ‘being’ towards women. This way of being, guided by the
midwives internal moral outlook, disposes the midwife towards a perspective of caring and reveals a personal motivation and intrinsic desire to do their best for women. Midwives evidencing this form of ‘moral being’ are described as acting in ways which show respect for others and consideration of their unique perspectives and beliefs. For the women in this study, excellent midwives are able to make them feel special and listened to, a valued and trusted partner in care and women have the feeling that they matter on a very personal level.

The concept of ‘moral being’ is concerned with the midwife as person first and foremost and arises out of the women’s understanding that the meaning of an excellent midwife is predicated on the midwife as a being in-the-world (Heidegger 1962). Previously, ‘being’ in midwifery has been more commonly associated with an emotional and/or physical presence or being-there-with (Fahy 1998, Leap 2000, Berg et al. 1996, Walsh 2006). However, in this case ‘being’ is considered in relation to the personhood of the midwife themselves, and contends that certain individuals have core virtues and attributes that predispose them towards the kinds of relational caring which are highly valued amongst the women within this study, a feature also mentioned by women in Thompson’s (2004a) study. Therefore this would seem to present an understanding of excellence in this context as centred in and originating from within the individual themselves.

This does not negate the value and importance of the professional virtues expected of midwives, such as competence, knowledge and experience, however the suggestion is that the ‘moral being’ of the person comes first and is a foundation that profession and practice are built upon. Moreover, since the personality and characteristics of individuals determine if experience is seen as a source of learning, or merely acts to reinforce static or non reflective practice (Woodward 2000), then the person of the midwife is central to continuing
development as a practitioner. This is illustrated by the women’s comments about how excellent midwives maintain a perspective of birth as unique and special despite constant exposure.

Although studies like those by Carolan (2010) suggest that students beginning their midwifery career may have a strong disposition towards the ethos of birth as a special time in a woman’s life, it is unclear if midwives in practice for some years hold the same passionate view or if through socialisation or work stress they have come to view midwifery as more of a job than a way of life (Kirkham 1999, Homer 2006). In Karen’s description of a midwife whom she considers has lost belief in the specialness of birth, the midwife’s comments about intervening to deliver the baby sooner may be no more than an indication that the midwife is concerned about the health of the baby and feels it wise to deliver the baby more quickly. However, it does not explain her attitude following the birth, when all is proved to be well and she is still unable to offer any praise for the woman’s achievement.

The women taking part in this study emphasise the importance of understanding that each woman’s birth experience is an important and unique event which will be remembered for a lifetime. Excellent midwives are able to demonstrate an understanding of this through their belief in birth and their ability to be truly sincere in their support for women. The suggestion is that there is a distinctive difference between midwives who are able to show genuine interest and excitement in birth compared to those who are merely going through the motions and using words that have become mere platitudes.

However, a strong belief in birth is not always considered to be a positive feature, as midwives with extreme world views about birth may become carried away with their own overarching constructions of what is best for the woman. In this way, the
professional ego (Hart and Freeman 2005) can lead midwives to disregard the woman’s contributions and wishes in the mistaken belief that they are acting in her best interests. Promotion of natural childbirth without intervention is often seen as a primary goal for midwives, however, not all women wish to birth in this way and the women in this study stress how important it is that midwives recognise what women want and support their choices, even if they are not what the midwife themselves would choose.

Tarlier (2004) suggests that an ability to build responsive relationships with women despite potentially differing world views reflects the moral and ethical knowledge within such relationships. In demonstrating trust and respect in their relationships with women, midwives will engender a reciprocal feeling of trust and respect from the woman. This includes the midwife’s respect for self as well as other. A feeling of being respected is mentioned as important to all the women and reflects the deontological view that moral autonomy means all persons have value and are therefore entitled to respect (Milton 2005). The women describe the relationship between themselves and their excellent midwives as a responsive one (Tarlier 2004) founded on an attitude of trust, respect and mutuality. This is particularly demonstrated in the way excellent midwives attitude is one of sharing. Excellent midwives are described as giving their time, knowledge and experience, and encouraging women to take an active part in decision making.

Many of the women in this study mention feelings of trust as important to their relationships with their excellent midwives, trust which was evident at two levels—trust-in and trust-from the midwife. The comments of the women within this study would seem to support De Raeve’s (2002) notion that patients generally trust healthcare professionals to act in their best interests, initially basing their trust in the midwife on her professional qualifications and in the institutional context in
which she works. Many of the women in this study describe their belief that qualified midwives must be competent and safe, by virtue of their qualification and of the institutional regulations in place for nurses and midwives within the UK.

However, they also reveal that trust-in their midwife was also related to their perceptions of the midwife's confidence, professional knowledge and experience and as they got to know them, trust was also related to how well the midwife was able to reach out to their unique perspective and to get to know them as an individual. The development of a strong relationship was considered to facilitate feelings of trust-in and most importantly trust-from the midwife, where women and midwives developed a mutual trust in each others ability to make the right decisions and choices. For women and midwives who do not have the opportunity to get to know each other, building up this level of trust may be much more difficult, resulting in a more superficial level of trust on both sides.

Excellent midwives are also consistently described as non-judgemental, a feature which may take considerable work on the part of the midwife. All individuals have their own views and opinions and as described by von Dietze and Orb (2000),

“judgements made about patients are arguably never made in a vacuum but always in the context of a particular set of values and dynamics around patient care” 

(von Dietze and Orb 2000:167)

Excellent midwives are those who are able to listen to women without prejudging what they have to say. Therefore, within responsive relationships, like those found between the woman and midwife, both parties must demonstrate respect of one another and of each others moral and ethical perspectives. Building good relationships while still holding differing world views reflects this ability to respect
another persons beliefs, while not having to compromise your own (Tarlier 2004). Thus enacting moral agency involves an excellent midwife’s ability to work within a shifting moral context ‘working in between’ (Rodney et al 2002:78) their own values, the mothers and that of the organisation to balance those competing values and interests. Excellent midwives are described as those who were able to successfully manage the tensions between the two, blending them seamlessly to provide an approach to care suited to each woman as an individual.

Therefore, this perspective views excellence as a part of the moral being of the midwife, a core feature belonging to the individual. This is considered the foundational element of excellence because the midwife’s moral being, their beliefs, values and disposition are directly related to how they manage the other elements of midwifery, the caring and the professional. Excellent midwives are described as being able to ‘be’ excellent, despite the competing tensions of their everyday practice and it is suggested that this is related to their ‘world-view’ and thus their way of ‘being’ a midwife.
‘Relational Caring’

The concept of relational care is defined by Van Der Hulst (1999) as:

“the professional acts of systematically carrying out specific activities in order to establish a relationship based on trust between care provider and care receiver, in which equality, self-activation and open communication are important elements, which facilitate the ‘natural’ birth process”

(Van Der Hulst 1999: 244)

Relational care might also be described as a way of recognising the inequity that exists between midwives and mothers and how the midwife works to find a balance in the relationship that is respectful of what each has to offer. Excellent midwives are guided by their moral being to tailor care to the needs of the each woman and to act as a mediator to support women in the real world. The women’s discussions clearly recognise that there are many factors which have the potential to affect the way in which midwives work and thus, the way in which they are able to relate to women and to provide care. However, excellent midwives are described as those who maintain a focus on meeting the needs of the woman despite these constraints, even doing the ‘little things’ for women that they do not expect and which are cited as making all the difference to women’s experience of birth.

Noddings has suggested that the ‘one-caring comes across to the cared-for in an attitude’ (2003:937-42), one of receptivity, making herself present to the one cared
for. In this attitude of receptivity the midwife is able to feel what the woman feels and to come to know what the woman knows. As she ‘receives’ the woman and works together with her co-operatively she establishes a climate of trust and participation. Her attitude of receptivity shows the woman that she is respected and trusted, that the midwife is interested in her as an individual and is open and ready for dialogue. This kind of dialogue is what Buber (2002) calls ‘true dialogue’, a conversation where both parties are orientated towards and truly hear each other. Really listening and through this coming to understand what women want, is identified as key to the descriptions of excellent midwives. Midwives ‘listened and understood’ the exact type of birth that Hazel wanted, and were able to make Susan feel ‘really special and listened to’, and this demonstrates their attitude of receptivity.

Although midwifery is considered to be a profession of caring, it is evident that those paid to care are not always caring (Tronto 1993). Within the women’s conversations there are examples of instances of care in which the midwives are not seen as caring, such as those demonstrated in the use of derogatory language and controlling behaviours. An issue for caring in midwifery may be linked to the increasing emphasis placed on academic qualification rather than a desire to care for others (Woodward 1997). While increasing the academic status of the profession may assist in equalising some of the power imbalances between midwives and their medical counterparts, this may only have the effect of devaluing the relational aspects of caring for women (Oakley 1993, Downe et al. 2007).

The descriptions of excellent midwives emphasise the personal perspective, often stating that excellent midwives are able to make women feel special and listened to, and this is important because women want to be treated as individuals and to
feel they are entering into a caring relationship with the midwife. As Noddings (2003) suggests, natural or real caring about requires that the one caring reach out to understand the perspective of the one who is being cared for and in this way the midwife is available to the woman and tries to see through her eyes and to understand what the woman wants, ‘seeing birth through different eyes’ (Karen Group 2). Consequently, caring ‘about’ rather than caring ‘for’ requires a meeting between those performing the act of caring and those being cared for which involves both participation and communication.

However, caring is not always a simple and straightforward process with both parties involved in the relationship agreeing on a course of action and midwives may find that the woman is asking something of the midwife that she feels that she cannot, in good faith of her own beliefs, concur with. In such situations Noddings (2003) suggests the midwife is required to examine her own personal rules of conduct to consider if what the woman is asking is merely uncommon or unorthodox, and is therefore only going against general guidance or socially acceptable behaviour, or if it breaks an absolute rule, one which the midwife can never violate. In this way, midwives may consult their own frame of reference, such as personal experience or practice guidelines, to decide to what extent this presents a conflict for them on an individual level.

This relationship of caring described as a feature of excellent midwives, in which there is recognition of the individuality of others and an openness to understanding an alternative perspective, is not always apparent within the mother-midwife relationship. As Mander and Melender (2009) found reality frequently does not match up to expectation, with women’s choices often limited to those options that are part of routine care or to those that are considered suitable by the midwife. Within my own study, the women describe how some midwives are seen as
controlling information, being resistant to questioning or using knowledge in such a way that choices are limited or by using information to scare women into acting in certain ways, using the concept of disciplinary power (Fahy 2002).

It is possible that this also recognises the potential double standard inherent within the healthcare model of informed choice. Although ‘informed choice’ is a concept which is at the core of modern maternity services and is often promoted as a way of involving women and their families in decisions about their care, in reality, women often find themselves directed towards choosing a course of action recommended by the health professional (Pollard 2010). Women who choose not to conform to accepted practices are usually considered to have an incomplete understanding of the issues involved or are thought to be lacking the ability to fully consider the implications. It is rarely considered possible that these women have fully considered the information and then have made a choice to follow a different course of action or to disregard the advice of the expert and this does not recognise the right of individual choice.

Relational caring might also be described as an attitude of compassion for another and in this sense removes the differentiation between people and does not define one person as being weak, inferior or lesser in any way and hence is not synonymous with pity. Compassion is not about what we choose to do for other people but what we choose to do together with them. This very much reflects the ethos of midwifery practice and the equal but different perspective of the women in this study. Excellent midwives are felt to focus on this aspect of being together with women, fostering a relationship of equality rather than dependency and working to create confidence and trust in the woman and in her abilities. This has the added effect of fostering good mothering and adaptation to motherhood after pregnancy and includes features such as adaptability, coping when things do not
go as anticipated and belief in self. Individuality is cited as key to this with the belief that excellent midwives need to be adaptable to be able to understand the woman and thereby comprehend what each particular woman requires.

Emphasis is often placed on transmission of information, in order for the women to understand, to make informed choices and to obtain consent, however, the space provided for women within modern midwifery care, to enable them to speak rather than listen, is minimal, if available at all. Listening is an art, the first step of which is to show that you are open to listening in the first place (Goleman 1999) and all the women taking part stress the importance of midwives listening and really hearing. For midwives communicating within Buber’s (2002) I-Thou position, both parties maintain their own ground and the dialogue in the midwife/woman relationship creates space for the woman in which the woman feels deeply listened to. This has the effect of humanizing the healthcare encounter and enabling the midwife to co-construct the history of the woman. In addition the midwife brings her own culture, beliefs and values to the encounter and together they create a new bi-directional and individualised model of care.

6.4 ‘Authentic Professionalism’

Authentic professionalism is a way of describing how the midwife demonstrates congruence with the woman’s expectation of her as a professional midwife. The act of professionalism commits the midwife to acting for the good and in the best interests of women and makes a promise relative to her professional status about what others should expect of her. Therefore, if the midwife is to be seen as a good
or virtuous professional she must demonstrate those virtues expected of her professional role (Pellegrino 2007). Multiple perspectives make this a difficult reality to live up to as the virtues prized in one perspective may differ greatly from another and could therefore be key to understanding why it is difficult to define the meaning of excellence within a list of essential and desirable attributes. Since what one person or one perspective may consider to be essential can be vastly different to another, it may also suggest that midwives would do better in women’s eyes if they focused on an individual philosophy for being caring rather than the more common approach to providing care (Woodward 2000).

The perspective of the women in this study assigns highest value to those virtues associated with human caring. In contrast, many midwives, particularly those working in institutional contexts, are encouraged to place value in medicalised and technological skills rather than those traditionally associated with midwifery practice (Pollard 2010), while the organisational perspective might be seen as placing highest value in utility and efficiency (Kirkham 1999). This is difficult because it represents very contradictory values that midwives are required to manage in their day to day practice.

Although the bulk of the women’s discussion within this study focused on the humanistic qualities associated with excellent midwives, all the women have an expectation of professional expert knowledge, skills and experience within their understanding of the meaning of an excellent midwife. Practical credibility, in the form of observable clinical skills and experiential knowledge, gained through attendance at many births, are the most frequently cited examples of this knowledge; however women also mentioned theoretical knowledge related to the midwife’s ability to provide evidence-based, up to date information to support women’s informed decision making.
It is interesting that although all the women in this study are therefore clear that sound professional knowledge – both theoretical and practical - is important, there is a high degree of assumption associated with these statements. Profession specific expert knowledge and skill is required to qualify as a midwife and regulation requires midwives to maintain and update their knowledge; therefore, there appears to be a general assumption that all midwives, by virtue of their professional qualification, will have the required level of knowledge and practical competence, a feature of belief in professionalism also described by de Raeve (2002). Experiential knowledge is felt to be slightly different, and recognised as something that a midwife will only be able to develop over time, however, all the women find it difficult to assess the degree of their midwife’s professional knowledge and skill and often experience is associated with superficial features such as age or length of qualification.

The overall perception amongst these women seems to be that because midwives are a regulated profession, who function within a gamut of professional rules, codes of practice and legal requirements, all midwives by virtue of their qualification are required to be, and therefore are, competent at the ‘professional’ level. This level of assumed competence and therefore, assumed knowledge, might also relate to the women’s feeling that midwives who were resistant to questioning or who were apparently withholding information were deliberately choosing not to share their assumed knowledge in order to exert power and control over them.

While this may indeed be the case, it is also possible that midwives simply did not know the answers to the questions asked but were unable to admit to their lack of knowledge in the belief that this might damage the image of their professional persona (Goffman 1959). ‘Intellectual honesty’ (Pellegrino 2007:76), in which the
midwife is able to admit the limits of her professional knowledge, is a key part of being authentically professional as this ensures that women are able to make informed choices about courses of action, even if this is to seek out information from an alternate source. Midwives who are not able to demonstrate this may only be thought of as controlling, which is just as likely to damage their professional relationships with women.

Although philosophies of midwifery care, such as partnership, are advocated as effective methods for balancing the inequalities of the midwife-woman relationship, midwives as experts in the field of childbirth, have a privileged position in relation to the women who seek their services, therefore, they will always be in a position of greater power. This is certainly recognised by many of the women in the discussion groups and they describe how midwives are seen to use their position of power, either to support or control women in two main ways, through the control of knowledge or by use of language. In contrast to this, excellent midwives are considered to offer women a range of information that they might need to make informed choices which includes explaining alternative options, being open to questioning from women and being honest when they don’t know the answer.

Some of the women within the group discussions consider that there is a bias towards technological and medicalised aspects of midwifery training, and a devaluing of the caring aspects of the role. This observation is perhaps reflective of other features than curriculum, such as the current dominant culture of practice within the NHS, one of recording and surveillance, where value is placed on acquisition of knowledge in the form of measurable practical skills rather than the more ephemeral and more difficult to quantify psychological aspects of care. It is perhaps easier to test and record progress by using hard skills, such as technical competence and knowledge rather than softer skills, like inter and intrapersonal
skills and Raphael-Leff (2001) has suggested that as a result of this midwives have found themselves becoming ‘competent technician’s’ (2001:230).

In the nursing context, Sumner (2010) suggests that a nurses identity is already defined though the role delineated by the lifeworld of the healthcare system in which they work and this might also be considered true for many midwives working within the NHS system. By this standard therefore, midwives working in institutional contexts, such as hospital labour wards, are expected to have very different philosophies of care in comparison to midwives working in community settings and this has been found in several studies of the midwives perspective (Hunter 2004, Hunter 2006a, Hunt and Symonds 1994, Van Der Hulst 1999). In contrast, the women within this study describe midwives whom they consider excellent in a range of practice environments, from less technologically focused community based independent practice to medically supported and highly technical hospital based practice. This suggests that, for the women in this study the meaning of an excellent midwife is not related to the context of practice or the model of care, but to the individual practitioner themselves, and this contradicts the idea of an identity defined by the practice environment, which is a somewhat surprising finding in light of previous understanding.

Consequently, while there is little doubt that the excellent midwives described in this study are under the same constraints and pressures as other midwives, indeed, this is frequently mentioned in the women’s conversations, excellent midwives are seemingly resistant to these external influences, enabling them to provide a ‘gold standard’ of care despite the apparent dichotomies of practice and the environment within which they work.
6.5 Conclusion

For excellent midwives, therefore, it would seem that their role is not defined externally but is guided by an internal and personal philosophy of care, a way of being, knowing and showing midwifery care, which enables them to consider the multiple perspectives of women, the system and profession whilst still maintaining the personal. This personal philosophy, perhaps what might be considered a personal ethic of care, maintains that which women value most about excellent midwives - the moral motivation to do their best for women, belief in the specialness of birth, respect for women as individuals and authenticity within their professional role.

The following discussion considers the midwives personal philosophy of care in more detail using the metaphor of the moral compass, to describe how excellent midwives might navigate the tensions of everyday practice and balance competing ideologies in order to ‘be’ excellent.
The midwife’s professional role is often a difficult one, attempting to straddle the conflicting ideologies of a ‘with woman’ midwifery philosophy on one side with an opposing, but no less influential philosophy of medicalised care on the other (Parker and Gibbs 1998, Blaaka and Schauer 2008). It is little wonder then, that many midwives report frustration, disillusionment and stress associated with balancing these contradictory philosophies and that the negative effects of such imbalance often leads to a loss of the humanistic elements of midwifery care most valued by women.

However, the midwives described as excellent by the women taking part in this study are considered excellent in spite of the acknowledged tensions inherent in their everyday practice. Excellent midwives are described as maintaining their belief in birth, making women feel special and listened to and showing care for and value of women as individuals, despite the apparent contradictions in their day-to-day practice. What then is different about these midwives, what is the essential quality which makes them excellent and how do they maintain their belief in the uniqueness and specialness of birth?

Although personal characteristics, professional knowledge, skills and experience are all highlighted as important aspects of the excellent midwife’s practice, and are
mentioned by all of the women taking part in this study, it would seem that to be an excellent midwife it is not enough to have the correct virtues, knowledge and experience but as Adams (2006) suggests, in order to be excellent:

“…..one must not only have a number of excellent traits. One must also have them composed excellently into a whole” (Adams 2006:32)

There is little doubt, that the excellent midwives described by women taking part in this study, are expected to have in-depth professional knowledge and skills. However, there is also a clear distinction between skills that midwives might have and the way that they are in their interactions and relationships. Although excellent midwives may be described in terms of the outwardly visible - things that they do, characteristics, attributes and knowledge that they have, they are also understood in terms of feelings, particularly the good feelings that they engender in others. The women in this study are clear; excellence is not about what midwives did for them, but how they made these women feel – trusted, respected and valued. Excellence might therefore be seen as a combination of right feeling and right action, described by Aristotle (Crisp 2000) as virtue.

Therefore, while the data indicates that the foundational element of excellence may lie within the moral being of the individual midwife, to be an excellent midwife also requires an understanding of how a midwife’s moral knowledge is used in conjunction with the knowledge, skills and experience of her professional role to create a complete, dynamic and fluid approach to midwifery practice. The moral compass is used as a metaphor to represent the way in which an excellent midwife is able to live midwifery, combining her ways of being, knowing and showing to form an excellent whole, as illustrated in Figure 1. This diagrammatic representation of the midwife’s moral compass was developed as a way of
illustrating the complexity and fluidity of everyday midwifery practice and how this is combined to form a way of being a midwife.

The following discussion explains these concepts in more detail with the aim of illustrating a theoretical perspective of individual moral and professional excellence.
Figure 1 – Original Diagrammatic Representation of the Moral Compass
7.2 The Moral Compass – A Conceptual Model of Midwifery Excellence

While inherent moral virtues may lie at the core of what it is to be an excellent midwife, and provide the motivation and belief behind right actions, these actions would not be possible in professional terms without the requisite skills, knowledge and experience. While being a good and virtuous person may bring rewards and recognition to an individual in and of themselves, to be a good and virtuous professional – to be excellent in terms of their professional role - requires that they are able to combine the personal and professional into an excellent whole. In addition, while good moral character may be seen as inherent to an individual, it should not be seen a fixed and unalterable state of being, but something which develops and matures over time and with experience in much the same way as professional knowledge and skills. I have therefore chosen to use a conceptual metaphor, the ‘moral compass’ (Figure 1) to describe the way in which midwives are able to ‘be’ excellent, using their moral sense of self, their moral identity, as a foundation for their midwifery practice.

In everyday terms, morality is usually considered to relate to an understanding of right and wrong, good and bad, and often has strong associations with religion. Therefore, the concept of the moral compass most commonly represents a universal or unwavering ethical approach to life within a social milieu, utilising fixed sets of rules or standards to guide ethical decision making. This situates the moral compass within the context of a template or tool, one that can be applied to situations in which ethical questions are raised (Thompson 2004b), or as a way of considering moral problems and making decisions that will be deemed right. The problem with this approach is that context varies considerably and what is
considered right by one social group may not be considered so by another, or perhaps even by the same group in a different context.

Within the field of healthcare, the moral compass is not frequently used, although it has been suggested as an off-the-shelf tool for ethical decision making in neonatal care (Stevenson and Goldworth 1998) and is also suggested as an alternative to a traditional code of ethics by the Midwives Alliance of North America who state that:

“a midwife must develop a moral compass to guide practice in diverse situations that arise from the uniqueness of pregnancy and birth as well as the relationship between midwives and birthing women” (MANA 2010)

The MANA description focuses on the moral compass as a guide to ethical decision making within midwifery practice which does represent a more personal approach. However, while it acknowledges the complexity and diversity of ethical contexts encountered by individual midwives, hence the value of a flexible and individualised approach, it would still seem to be orientated towards an understanding of the moral compass as a tool for guiding ethical actions rather than as a way of ethical being.

In geographical terms, a compass is a device by which to determine direction, its magnetic needle mounted on a dial of north, south, east and west, free to pivot towards alignment with the earth’s magnetic field and providing a stable point of reference. However, while a compass always points to north, this does not represent a completely fixed and unchanging point of reference, with magnetic north exerting more influence as the compass moves towards it, requiring attention and adjustment to maintain the right direction. In addition, a compass may provide
information about direction but is cannot make decisions regarding the destination, the mode of travel or the length of the journey.

The points of the compass may also represent more symbolic meanings, suggesting direction in life, rather than in geographical terms, as found in ancient Chinese, Celtic and American Indian culture. For the Chinese, north represents adaptability, creativity and sociability, in Celtic symbolism it stands for home, security and fertility while for Native Americans north is aligned with wisdom. Therefore, while a compass may provide direction in the physical and practical sense, it may also present an understanding of meaning and direction on a more meta-physical level.

Most explorations of what it is to be an excellent nurse, midwife or doctor, result in a list of virtues or morally admirable traits of character (Slote 1992) that excellent practitioners are deemed to possess. However, while these are often identified, there is rarely consideration of how these virtues contribute to excellence and it is not clear if practitioners require all or only some virtues to be considered excellent. In this study, women identify many of those virtues also mentioned in other explorations, however, the key difference would seem to be the women’s emphasis on an understanding of excellence as centred within the individual themselves. Therefore, excellence is not considered to rest simply within the actions and behaviours of midwives, but also within their moral self, so that, like Adams (2006) and MacIntyre (2007), the character of the individual is considered most important and good moral character or virtue is understood as what it is to ‘be’ good, rather than what it is to ‘do’ good.

Therefore, my own interpretation of the moral compass (as shown in Figure 1) is offered as a metaphor by which to explore the meaning of an excellent midwife,
combining physical and meta-physical meaning, a point of reference and direction and a flexible and fluid approach, whilst taking into account internal and external influences to provide a coherent whole. This provides the midwife with direction and purpose, in much the same way as the magnetic north of the compass, and provides a point of reference to self, by which she can judge her practices, whilst still allowing for change over time and with experience.

Furthermore, although the midwife’s moral core may provide her with direction, a guide to what she ought to do, she still has to choose how she will act. The midwife’s moral identity, a fusion of her personal ethos and vision, is balanced with her moral agency, her ‘capacity for moral choice and action’ (Thompson 2004b:34) and there is recognition of the diversity of external influence which acts on the midwife both as an individual and as a midwifery practitioner. Therefore, if we consider midwifery excellence, and striving for excellence as the midwife’s direction, the way in which she moves towards this is individual, contextual and situated, based on her own ideas of midwifery rightness.

Although the moral identity shown within the moral compass (Figure 1) describes an individuals understanding of themselves, within the context of their personal and professional lives, this does not demonstrate an egoistic focus because it actively seeks to be open and available to others whilst retaining a strong sense of self (Galvin and Todres 2009). Since Gilligan (1982) maintains that an ethic of care is defined by its relational quality, a concern for the wellbeing of others (Fine 2007), the midwife seeks to understand herself but she must also understand herself within the context of others and others within the context of their own lives.

Therefore, while some may consider that a moral compass demonstrates an egocentric approach to midwifery practice, an altruistic motivation underlying
actions is embedded within the individual as an embodied moral practice of caring. Indeed, since attentiveness to others, or as Tronto (1993) describes it, a disposition towards, is considered the primary moral aspect of caring, a personal ethic of care is an essential part of excellent midwives moral identity and this maintains a balance between a focus on the self and an altruistic desire to act in the best interests of others. This attitude of caring is one that is frequently described by the women in this study, particularly when it is felt to be absent within the caring relationship, resulting in women feeling like objects, being handled by formula (Noddings 2003). Excellent midwives are considered to be exceptionally caring, whilst also still demonstrating integrity to their own personal and professional values.

The representation of the moral compass within this study is considered to be more of a point of reference to self, and represents a constant presence, in the form of moral identity, situated within the context of the midwife’s life and as such is individual and particular, representing a fusion of her life experience and knowledge. This means that an individual’s moral compass is non-transferable, what would be right for one midwife would not necessarily fit with the visions and values of another. Moreover, because both the self and moral reasoning are fluid and contextual (Ryan, David and Reynolds 2004) the moral compass is constantly being modified, changing over time to reflect new knowledge and new experience. Therefore, the moral compass is considered to represent an idea of individual rather than collective moral knowledge, a way in which a midwife is able to develop through reflexive learning. This form of developmental and experiential knowledge might also be considered to demonstrate wisdom or expertise in the conduct and meaning of life (Baltes and Staudinger 2000).
By returning to her moral identity, the point of continuous reference to self, the midwife is able to reflect on her beliefs, ideals, values and knowledge (Lindh et al. 2009) and consider how the values from her personal and professional life combine to create her vision of midwifery and thus denote the kind of midwife that she wishes to be. Reflection and integration of new experiences allows the midwife to modify or enhance this position according to her individual embodied experience and through this process her sense of self and her professional identity may change and develop. Since this is linked with an understanding of growth in the moral sense, in becoming a better person and in this case, a better midwife, this might also be linked with concepts like Maslow’s (1970) self actualisation or enlightenment (Gilbert 2007) as described in Buddhist philosophy.

In geographic terms, magnetic north may be seen as the sum of all magnetic influences therefore, although there is pull from all directions of the compass, alignment with the north-south line remains the strongest influence. In midwifery practice, this same effect may be seen because although a midwife’s practice is influenced from many diverse directions, her moral compass (Figure 1) her ethos and vision, can provide the strongest influence on how she acts. In everyday midwifery practice, midwives may feel the pull of the competing ideologies and perspectives which surround them and which can make it difficult for midwives to maintain their own vision and beliefs. Excellent midwives are those described as being able to maintain their vision of midwifery despite these competing demands and this may be related to the strength of their moral identity also considered as moral strength (Lindh et al. 2009).

In this study, the environment of practice is considered to exert considerable stress on individual midwives, and is often offered in mitigation where midwives are considered to have acted inappropriately, or in what is considered a less than
ideal way. However, one of the most significant features of excellent midwives is described as their ability to maintain ideal practices even in situations that the women recognise as difficult or stressful. Although the women did not articulate how excellent midwives are able to achieve this, my understanding is that this is related to their moral compass and to the strength of their vision and ethos.

The midwives core values – the vision, character and values which make up their moral identity, act as a point of reference, the midwife’s magnetic north so that, while the midwife may be exposed to many competing perspectives and opinions, she is able to consider these perspectives within the context of her own moral identity. This means that the midwife is able to ask herself if she is acting authentically, that is she is acting in a way consistent with her own understanding of what is the right or best thing to do and in the way most likely to accomplish her vision of midwifery practice.

When a midwife’s actions are motivated internally in this way and she is able to act authentically within her own moral framework, in Aristotelian terms she is doing something she considers right and through this she is able to gain emotional reward from the act itself, rather than from any potential result (Banks and Gallagher 2009). Acting well and in accordance with her own vision of midwifery and of life, makes the midwife feel good about herself. Consequently, she generates her own internal emotional reward through her actions, rather than relying on emotional reward from the person towards whom she acts.

Therefore, midwives described as excellent may be gaining a sense of fulfilment through the ability to act authentically to their own vision of midwifery practice, rather than through their relationships with others, as more commonly described within current midwifery discourses. This may provide a degree of emotional
resilience in situations where the formation of relationships is difficult and may explain how excellent midwives are able to maintain their vision and belief in midwifery, women and birth, despite the apparent contradictions and stresses in their day to day work environments. This would suggest that midwives who consult their moral compass frequently, and ask themselves if they are living midwifery in a manner which is authentically real to their vision of midwifery practice, are more likely to continue to act in ways which are consistent with their own vision of excellence. Since excellence is considered to exist as a striving to be the best one can be, this is a constant process, in which the midwife reflexively questions and examines her vision in order to improve it as time goes by. In contrast, midwives who only consult their moral compass infrequently may find that their actions become random, routinized and non-reflective as described by Woodward (2000).

This idea of the moral self, and of the midwife’s practices as fluid and contextual, might also be considered within the perspective of Goffmans (1968) moral career. The moral career is understood as a combination of the effect of internal influences, how a person views themselves and how they experience their identity and motivation, with external influences, such as institutional and organisational systems and ideologies. Over time and with reflection on self, individuals may alter or modify their view of themselves and of their personal identity and moral direction, hence the moral career is dynamic and evolving, perhaps involving significant change over time but requiring constant reflection, readjustment and integration of new ideas and experiences.

In terms of everyday practice, midwives may often find that there is a contradiction between what is desirable, what they know to be good and what is actually possible, given the confines of time, finance and institutional control. Although moral decisions made in the midwife’s professional context may be considered
right if they follow the conventions set within professional expectation (Pellegrino 2007), for them to be considered morally good from the individual midwife’s perspective, they also have to agree with that individuals self-concept of what is right. Since individuals and situations vary considerably, this presents a challenge for midwives who may often be required to manage tensions created between what is expected of them within their professional role and what they expect of themselves as morally independent individuals.

Since life is complex and challenging with circumstances changing constantly, an ability to be flexible and resilient may represent the excellent midwife’s ability to maintain the more personal elements of care, despite pressures of time and other features within the work environment. This suggests that although excellent midwives recognise the pressures of the work environment, their own core beliefs provide enough stability to enable them to manage these to the extent that they are still able to continue to provide care which is consistent with their own personal ethic of care. Moreover, this also provides an intrinsically based motivation towards caring, based on a desire to act in ways which are consistent with their own moral identity and which bring emotional reward through the actions themselves.
7.3 Individual Excellence

Although the concept of holistic care in midwifery recognises the interdependence and interaction of the mind, body and spirit with regard to understanding women’s needs (Tiran 1999), it is interesting that this same approach to the holistic understanding of midwives themselves has been rarely considered. Midwives are individuals who exist as beings outside of the profession of midwifery before they become midwives, indeed it might be surmised that some feature of their pre-midwifery character is what brought them to midwifery in the first place (Hall 2000). Therefore, any holistic understanding of the midwife also requires considering the midwife as a being independent of her midwifery professional role as well as within it, and of those other features and attributes which are intrinsic to her as an individual.

Midwifery practice is based on a philosophy of being ‘with woman’ and therefore requires that midwives are able to engage with women and others in meaningful ways. However, previously there has been little consideration given to understanding what this means in terms of the midwives moral being and to how this may impact on her interactions and relationships with others. While the idea of understanding oneself and the effect this may have on social relations and work life is becoming more popular, particularly within concepts such as emotional intelligence (Goleman 1999, Akerjordet and Severinsson 2007, Bulmer Smith, Profetto-McGrath and Cummings 2009, Gardenswartz, Cherbosque and Rowe 2010), this is still a relatively underexplored area, especially within midwifery.
Self-knowledge, or knowing for oneself (Gadamer 2004) is important because, as Martin Buber (2002) suggests:

“in order to be able to go out to the other you must have the starting place, you must have been, you must be, with yourself” (Buber 2002:627-637)

Therefore, for midwives, knowing oneself and understanding the motivations, beliefs and desires that represent both their way of living life in general and living midwifery, in particular, may have important consequences for how they make judgements, especially since these may be based in ‘our own sense of moral integrity’ (MANA 2010). In addition, such knowledge of oneself may provide a strong foundation of belief that supports a way of living in the world consistent with the individuals own understanding of right and wrong. This can be particularly important for midwives due to the pluralistic nature of midwifery practice and the contradictory philosophies of care found in everyday work life.

Aristotle’s use of the term self-knowledge explains a form of knowledge specific to the moral being of the individual themselves, a moral consciousness, or way of knowing that guides right action. Moral knowledge is seen to differ from other forms of knowledge, such as technical knowledge, in that it is has no specific end in mind but rather is concerned with the right way to live ones life and is based on an understanding of life as contextual and subjective (Gadamer 2004).

While technical knowledge is explicit, known in advance and applicable given the right situation, moral knowledge consists of more general principles. These act as a guide for individual action but due to the nature of moral knowledge as time and
context specific, actions cannot be known in advance and have to be flexible in order to respond to demands of situations that are constantly changing. In this study therefore, self-knowledge is considered to represent an understanding of oneself as a moral being within a complex and unstable environment, just the type of environment within which midwives may find themselves in their daily lives and practice.

Therefore, the development of moral knowledge and through this good moral judgement requires midwives to combine practical experience with an understanding of what is considered right and wrong, such that they are able to develop an appreciation of the moral significance of different outcomes (Jacobs 2002). In this way, the virtuous midwife is able to demonstrate not only understanding of the situation but also the appropriate feelings to deal with a situation correctly. This may help the midwife to put herself in the place of the woman, utilising a combination of moral imagination, moral perception and moral sensitivity, collectively considered moral wisdom (Armstrong 2006), to better understand the woman’s unique perspective and to consider how it may differ from her own.

Thus the desire to make a difference, often cited amongst reasons for becoming a midwife (Carolan 2010) might also be understood from the moral perspective, as moral strength (Lindh et al 2009), the aspiration to be seen as someone special in the care of patients (Lindh et al. 2009). Moral strength is therefore a concept which describes an individual’s relationship with their own moral beliefs and principles, a way of knowing or ethos that is directly related to judgements for action.

However, making decisions and acting on judgements in practice often presents complex and contradictory decisions for midwives as they struggle to reconcile
their own moral consciousness with the demands of others. To be able to act in ways which are consistent with individual moral principles and convictions yet also recognise the needs of others requires that midwives have a strong sense of self, yet are open and available to others (Galvin and Todres 2009). This requires the ability to see themselves not only as individuals but also as part of a common humanity, as part of a larger whole (von Dietze and Orb 2000).

While the women in the discussion groups, like participants in many other studies, find it difficult to pinpoint the exact meaning of excellence, within their discussions as a whole, there is a definite feature, understood as intrinsic to the individual themselves and separate to the professional role, that may be seen as at the core of the excellent midwife. All the midwives described as excellent are considered to have this special quality, and it is interesting that this is considered to reside in the individual themselves, as something which the midwife brings to midwifery with her, rather than acquires as part of her midwifery training or professional education.

Therefore, underlying the individual attributes or virtues by which excellent midwives are described, there would seem to be a broader concept of excellence, one that becomes evident only when they are merged into a whole. This might be considered what Adams calls the ‘holistic property of having good moral character’ (Adams 2006:32). Although virtue may be most often represented in the good traits of character that individuals possess (Koller 2007), Adams makes the distinction between this and his understanding of virtue as a ‘holistic property’ of being. In this way, virtuous individuals are seen as not only having traits of character that are considered good, but of integrating them in such a way that it becomes part of their way of being, a way of living that is ‘being’ for good.
One way in which this integration occurs may be anchored in the motivation for action which comes from the individual themselves. As suggested by Hurka (2006), an understanding of virtuousness rests on the motivation underlying actions, and agents acts are considered virtuous only when they are motivated by a desire for good, usually for others. Although virtues as character traits are often cited as key elements within descriptions of good, ideal and exemplary midwives and, while they may predispose individuals to act for good, individual midwives still have to exercise choice in how they act. Excellence of moral character or virtuousness, is thereby characterised by the individuals motivation to act for the good (of others) and not simply by having ‘good’ traits of character. In Hurka’s (2010) terms, this implies the same kind of integrated perspective on moral being also suggested by Adams (2006).

An understanding of virtue as a property of being compared to a focus on the possession of various good traits of character, might be considered similar to the existential difference between ‘having’ a profession, i.e. having a midwifery qualification, and of ‘being’ a midwife. While having a qualification is required to practice as a midwife, ‘being’ a midwife suggests that the practitioner has assimilated their professional role into the core of their being and beliefs in such a way, that their perspective has become ‘permanently altered’ to reflect the virtues of said profession (Pellegrino 2007:81). However, this study suggests the possibility that excellence, and thus the virtues associated with professional ideals, are present as intrinsic qualities of the individual that precede professional being. In this way, excellent midwives bring excellence in being to their professional role, and then become excellent midwives as they assimilate the necessary knowledge and skills of professional midwifery practice into that being.
This is an interesting perspective and one that others, like Nicholls and Webb (2006) have also questioned - are those qualities associated with excellent practitioners present when they begin their midwifery training or can they be developed and taught. The comments of the women in this study, suggest an understanding that although these qualities can be developed through education and training, it is felt that they have to be present in the individual already. Many of the women were of the opinion that individuals who lacked the intrinsic quality of excellence, what might be considered as a moral orientation towards care, might never be able to develop it.

This view may be supported by others who have described excellence in a variety of practitioners, at all levels (Kendall 1999, King and Macleod Clark 2002). If excellence can be considered part of the intrinsic being of an individual, then it may explain how excellence can be described even in very inexperienced practitioners. Although a novice midwife may not have acquired enough profession specific knowledge, experience or skill to be considered an ‘excellent midwife’ in the professional sense, they might still be considered excellent in the individual or personal sense.

It might therefore be postulated that individual excellence, or excellent moral character or virtuousness, represents the ‘special’ quality that makes a practitioner ‘stand out’ amongst others, yet is so difficult to describe. An understanding of excellence in this way would also be consistent with Kendall’s (1999) view that ‘star quality’, her term for outstanding nurses, is often identifiable at a very early stage of an individuals professional career.

Excellence as a way of being is also consistent with Aristotle’s view of the virtuous individual, living an excellent life in which desire and reason are aligned (Jacobs
However, Aristotle also places emphasis on the importance of aspiring or striving to be good (Banks and Gallagher 2009). Since moral character takes a long time to develop and is also dependant on good role models (Athanassouli 2004) striving for good provides the motivation for continued growth and development of ones character and for continued vigilance in right feeling and right action. It might also be seen as a way of promoting reflexivity within the midwife’s practice and thus recognition and internalisation of personal and professional goals to promote quality midwifery practice (Woodward 2000).

The truly virtuous individual acts out of choice, rather than habit or duty and is informed by understanding and knowledge of the right thing to do and the right time to do it (Athanassouli 2004). Virtue also brings its own rewards, and both Plato and Aristotle (Jacobs 2002) considered that virtuous action was in the best interests of individuals because the act of doing good resulted in feeling good, not because of the outcome, but by the nature of having acted in a morally right way. This is also an interesting feature and may be critical to understanding how excellent midwives are able to maintain their perspective and beliefs, despite the tensions of practice.

In this way, judgements are based on a lifetime of judgements and experience that include moral knowledge or moral consciousness (Gadamer 2004). This blend of knowledge, understanding and moral judgement might also be understood in terms of wisdom (Baltes and Staudinger 2000), or in Aristotle’s terms as phronesis (Gadamer 2004) or the ‘practically wise person’ (Jacobs 2002:91), an idea that reflects experience through living (a good life). This might also be related to Heidegger’s (1962) understanding of being as a relationship with the world, a relationship that requires time for thinking, reflection, discovery and through this learning about the world and about ourselves in-the-world.
Practical wisdom of this kind is considered essential in the women’s understanding of what it is to ‘be’ an excellent midwife and demonstrates the importance of what could be considered the vocational elements of midwifery practice. Although theoretical knowledge is considered important, the experiential knowledge gained through attendance at many births is considered just as vital. Indeed, many of the women seemed to place much higher value on this aspect of a midwife’s practice, commenting that the knowledge that their midwife had attended many births led to greater feelings of safety and of trust.

However, it is also interesting that women did question if multiple exposure to birth was always beneficial and it was considered that some midwives became desensitized due to frequent exposure rather than gaining from the experience. This suggests that the link between experience and self knowledge is an important contributor to an understanding of practical wisdom. Excellence therefore, might be understood in terms of virtue and wisdom, representing a synthesis of the moral and practical knowledge and experience of an individual, which motivate towards individual excellence (Baltes and Staudinger 2000).
7.4  The Midwife’s Vision of Practice

The caring behaviours of midwives are a consistent feature of the women’s discussions in this study, and whilst professional knowledge, skill and competence are expected, the main focus of attention relates to the ways in which midwives showed (or did not show) care for women. This is described in a number of ways, representing the diversity found in approaches to care which are dependant on context, social and institutional norms and the relationship dynamics of those involved (Sevenhuijsen 1998).

Therefore, although midwifery has its foundations in the caring activities of the midwife, increasing professionalization and social change mean that expectations of care on both sides of the relationship have changed significantly. Midwives are expected to be professional and caring, two positions that often represent very contradictory and competing ideologies (Woodward 1997, Noddings 2003) and thus requiring a complex balance of the personal and professional, the humanistic and scientific and the expressive and instrumental (Figure 1). This creates a number of challenges for midwives, and the following discussion considers how a midwife’s individual ethic of care expressed within her vision of midwifery practice may help mediate this process.

Caring is often represented as one of the most basic of human characteristics and as such is considered to be part of all human beings (Tronto 1993, Tschudin 2003, Slote 2007). However, for the purposes of this thesis caring is understood in terms of being a personal moral practice, developing over time within the individual and representing a synthesis of their moral knowing and experience, centred on an
understanding of oneself in relation to the world and others. This might also be seen as a morality based around personal conceptions of care and responsibility (Gilligan 1982) or as described by Chattoo and Ahmad (2008) as:

“an embodied, moral practice within a theoretical framework of relational ontology” (Chattoo and Ahmad 2008:551)

The philosophy of ‘with woman’ care (Hunter 2002, Page 2003, Parratt and Fahy 2003) and a growing emphasis on partnership working (Freeman et al. 2004, Freeman 2006, DH 2004, 2007, 2009), reflect core ideals within the midwife-woman relationship, promoting a close and open relationship in which the midwife and woman can get to know each other and often considered the gold standard (Homer 2006). This is also conceptualised as a ‘reciprocal relationship’ (McCourt and Stevens 2009:33) in which both parties benefit in psychological terms. In this way women are supported through their childbearing experience in a way which meets both their physical and psychological needs, while midwives gain emotional reward within and from the relationship with women. Such relationships are credited with providing positive and empowering birth experiences for women, and satisfaction and professional growth for the midwives involved (Page 2003)

While a relationship of reciprocity might be considered ideal and is no doubt beneficial for many women and midwives, there are a number of issues that arise from its focus on the formation of relationships based on close personal and emotional involvement, particularly when developing an understanding of midwifery excellence. It also presupposes that all women, given the same opportunities, want to develop such relationships with their midwives, however, it is not apparent if this is actually the case.
For many midwives and women in the current systems of the NHS, the development of close and personal relationships is unlikely, given that the opportunities for getting to know each other are limited, particularly in the institutional context. There is already significant evidence within the midwifery research literature of differences between the quality of relationships between women and midwives in hospital and community environments (Van Der Hulst 1999, Hunter 2004, Hunter 2006a, McCourt and Stevens 2009, Pollard 2010), and in these, there would seem to be a suggestion that community based services offer a superior service for women, at least in terms of the relationship model of care.

Therefore, for midwives who work in non-community environments, attempts to work towards professional ideals based on relationship focused models of care but within the constraints of the institutional context, may be particularly difficult. Although individualised care may be recognised and promoted within midwifery professional discourses, it is rarely valued within the utility driven institutional context of the modern NHS (Kirkham 1999). At the present time, this would seem to be leading to a two-tier system of care in which both women and midwives are disadvantaged, as the ideals of practice are presented in ways which may be unachievable for many women and midwives.

Although the numbers in this study are very small, amongst the women taking part there is a range of birth experience represented, in both community and hospital settings, and all met midwives whom they describe as excellent. While several of the women met their excellent midwives during their pregnancy and they were able to get to know each other and to develop the kind of personal relationship advocated as the gold standard of maternity care (Homer 2006), many of the others met their ‘excellent’ midwife only during labour, and at least one woman
met her ‘excellent’ midwife for a few hours only, at the end of a long labour with multiple carers. However, all these women describe midwives whom they valued and trusted and who made a difference to their birth experience. It is therefore evident that excellence can be found in the caring practices of midwives within many contexts of care and therefore, the context of care may actually be less important than previously considered.

Perhaps the key difference is that these midwives are not described in terms of relationship, although features of relationship are mentioned, and the relationship between the woman and midwife is not considered the defining antecedent of excellence. Instead excellence is considered to relate to the qualities of the individual themselves, their ways of relating to women and their professional role, and their personal beliefs and understandings about life and midwifery. This might be considered a way of ‘being’ an excellent midwife - caring based on an understanding of care as a personal moral practice and coming from within the midwife themselves as described in the earlier part of this discussion. It also represents the midwife’s vision of midwifery practice, her understanding of what it is to ‘be’ a midwife and of how she should be as a midwife.

This is an interesting perspective, because it shows that for the women in this study excellence is not defined within the professional role itself nor within the rules and regulations of practice but is linked with the individual themselves and with an understanding of care as a personal morally led practice. While women do emphasise the importance of professional skills and knowledge, and there is a general assumption of competence because of a midwife’s professional qualification, the professional aspects of care, techne and episteme (Gadamer 2004), are considered to be ones that can be taught and therefore, might be acquired by anyone given time and the correct training. In contrast, excellence is
considered an intrinsic quality of the individual, something that can be learned by the individual but not one that can be taught or instilled in another.

While midwifery as a profession has a collective vision of what a midwife should be, of what MacIntyre (2007) describes as an understanding of virtuous practice, defined within the practice itself and representing a tradition founded within the historical and cultural environments in which it developed (Leeper and Leeper 2001, Hovey 2006), at a more individual level, what it is to ‘be’ an excellent midwife is likely to be defined within the individual themselves. This represents the midwife’s own vision of midwifery, one that is drawn from an understanding of midwifery within a wider context, but which has its foundation within the ethos (the character, fundamental values and beliefs) of the individual themself. This combination of ethos and vision might also be described as the midwife’s moral identity, a way of understanding herself as a moral being (Thompson 2004b) and of thus knowing how she should act.

Although many approaches to midwifery care seem to be focused on reducing the gap between midwives and women, it is important for midwives to recognise and value difference. In terms of understanding the other, or in this case understanding the needs of women, midwives have to be able to recognise and acknowledge the pre-ontological assumptions that they may have already at hand (Tapper 1986), those that are based in their pre-existing knowledge of midwifery and midwifery care. All of the women in this study, and in others (Berg et al. 1996, Berg and Dahlberg 2001) emphasise the importance of being recognised and treated as an individual, therefore it is important that midwives recognise themselves and women as separate entities. This supports consideration of the women’s needs as the woman sees them, by encouraging the midwife to interpret what she sees from
her own perspective within the framework of the language and meaning used by women (Noddings 2003).

Such an approach contrasts with the current dominant ideologies, which encourage midwives not only to be open and available to women but also to engage in a high degree of empathic identification, which may leave them open to personal feelings of distress (Hunter 2006a). While empathy is often associated with caring (Slote 2007), empathy involves projection of feelings, an attempt to understand how the other feels by asking ‘how would I feel in this situation’. This has the effect of personalising the feeling to the midwife concerned with the aim of making the others concerns more central and immediate. However, this has already been recognised as problem for midwives in two ways, firstly because it assumes that the other feels as the midwife does in this situation, potentially leading to misrepresentation or loss of the woman’s individual perspective. Secondly, over-identification with women’s feelings, especially in traumatic situations may lead to feelings of distress in midwives similar to those of the woman, resulting in secondary post traumatic stress (Leinweber and Rowe 2010).

This may come from an understanding of availability as a willingness to give of oneself for the benefit of others, to open up and make available ‘ones personal centre’ (Pembroke and Pembroke 2008:324) and thus invite the other and their experience into oneself. While Noddings (2003) agrees that caring involves feeling with the other, she rejects the notion of empathy, and suggests that feeling with represents a temporary suspension of self to consider the feelings of the other, without internalising those feelings to oneself. Similarly, Tronto (1993) who prefers the term responsiveness, considers that :
“Responsiveness suggests a different way to understand the needs of others rather than to put ourselves into their position. Instead, it suggests that we consider the other’s position as that other expresses it. Thus, one is engaged from the standpoint of the other, but not simply in presuming that the other is exactly like the self” (Tronto 1993:136)

This represents a way of understanding the other that can maintain the unique identity of the woman and the midwife. Thus the midwife does not internalise the woman’s feelings to herself in order to understand, but rather considers them as the woman expresses them. In this way, the midwife can be open and available to understanding by recognising that her own perspective may be very different from that of the woman’s.

Approaching understanding in this way may have a multiple benefits. Since there will always be a degree of inequality between mothers and midwives within a professional relationship of caring (Leap 2000), thus an ethic of care which recognises ‘self’ and ‘other’ as of equal value is not focused on trying to reduce this but in being open to exploring the possibilities that are found in each. This might be described as a way of valuing what each has to bring to the experience, and represents the concept of ‘equal but different’. In this case equality is considered as present in the humanistic perspective of human value, in which all humans are considered of equal value and as such entitled to respect, while difference refers to the individuality of personal existence hence their unique identity and experience. This also represents the moral and ethical knowledge required to develop relationships in situations where there are different world views (Tarlier 2004).
Many women mention how feeling respected and trusted by their excellent midwives, to know their own minds and to make their own decisions, is instrumental in the formation of good relationships and in their ability to feel safe and in control of their pregnancy and birth. Baier’s (2007) view, that virtue contributes to the development of these trusting relationships, is built on the premise that trust requires a recognition that we are all to some extent in the power of others. This is also a concept suggested by MacIntyre (1999), who considers that individuals must first acknowledge their dependence (at some time in their lives all individuals are dependant on others) before they develop independence. This requires an acceptance of their own vulnerability (Butts and Rich 2004), something that can be difficult for midwives within a professional-patient relationship. This suggests that a strong sense of self, a strong moral identity, may support midwives in overcoming issues of power and control, such that they are able to become vulnerable to women, and thus facilitate trusting relationships.

Furthermore, recognition of others as self determining individuals facilitates a change in how responsibility is understood. Instead of the midwife feeling entirely responsible for the wellbeing of the woman, the midwife is able to recognise that her responsibility extends only so far as her own actions. She may be responsible for ensuring that she does all that she can to provide information and to help support women in making choices but the woman, as an independent individual, is ultimately responsible for herself and her own actions.

Approaching care from the perspective of a personal moral practice, means that midwives might be considered morally responsible ‘to’ women rather than ‘for’ them. This means their responsibility rests in acting towards women in a particular way, one that is consistent with their own moral beliefs of right feeling and right
action, and not in acting for women. Although this may be a somewhat controversial idea, and one that might at first seems to be at odds with the advocacy role of the midwife, this is consistent with an understanding of autonomy, whilst still being wholly compatible with advocacy. Advocacy can be seen as a function of responsibility ‘to’ when the midwife acts in support of a woman’s choices and rights.

This approach to care is also likely to be of benefit for midwives, particularly in situations where women choose to make decisions or to take actions that are in conflict with those of the midwife. The midwives in the study undertaken by Hunter (2006a) demonstrate a range of emotions that could be considered consistent with a responsibility ‘for’ approach, particularly in the ‘out of balance’ exchanges described (Hunter 2006a:317) and in which women are considered to be resistant to contact, refusing help from midwives and ignoring advice. While it may not be possible to wholly remove the personal feelings of responsibility that midwives working closely with small groups of women often build up, understanding that women have the right to choose and to make their own decisions may help midwives to view these women’s behaviours from a different perspective than their own.

In addition, because the identity of the woman and midwife are maintained as separate entities, midwives may feel less threat to their personal and professional integrity. While it is not possible for the midwife to remove her own perspective from the situation completely, an understanding of individual beliefs and concerns could provide the starting point for understanding that women may choose options that seem unusual or even dangerous from another’s perspective, even if those reasons are not wholly apparent. This may form the basis for an exploration of the woman’s judgements in order to reach a deeper level of understanding and may
offer midwives a way to consider the woman’s perspective and respect the decision that she has made, even if they do not agree with it personally.

Maintaining a belief in women and in the specialness of birth is cited as a major feature of those midwives described as excellent however, although this is frequently mentioned in the women’s discussions, understanding why these midwives are able to do this when many others are considered to have forgotten this aspect of care was not explained. One suggestion, is that the midwife’s moral motivation towards caring and her vision of what midwifery practice should be, supports her ability to maintain a perspective of specialness, seeing each woman and each birth as a new and unique experience. This is no doubt supported by an ability to blend the personal, relational and professional aspects of her role and to maintain balance amongst these often conflicting ways of being.

7.5 Vignette – Demonstrating Excellence

The midwives described by the women in this study are considered to exist within three dimensions of excellence – those of being, knowing and showing care and the moral compass is used as a conceptual metaphor for how these fuse within the being of the midwife herself to provide a personalised framework for life and for midwifery. The midwife’s moral being, described as a way of being towards women and providing an intrinsic motivation towards doing her best, means that excellent midwives show respect for others opinions and perspectives and these midwives are described as being able to make women feel that they matter on a very personal level. Alongside this, excellent midwives use a blend of professional
knowing and relational caring, to support women’s choices whilst also remaining authentic to the responsibilities of their professional role. This requires a complex balance between the personal and professional beliefs of the midwife and those of others, something that is not easy, particularly given the tensions inherent in everyday midwifery practice.

The following vignette is offered as a descriptive example of these dimensions of excellence within a clinical practice setting. Although this story is fictional, it is drawn from my own experiences of midwifery practice and these are blended with the words, opinions and ideas of the women who participated in this study.

Jo arrives for her shift ten minutes early and makes her way into the labour ward office where everyone is starting to gather for the handover. The office is busy with the night staff finishing up notes and the day staff arriving to take over, so Jo settles herself in a chair near the door, exchanging greetings with those bustling around her and waits while a few more people arrive and handover begins. ‘We’ve had a pretty busy night’ says Sara, the nightshift co-ordinator, ‘but we’ve delivered most of them for you, there’s only one in labour now, Trina Wells in room 6, 25 and already on her fourth pregnancy and having twins! I think she’s going to be your problem for the day. She’s one of those earth-mother types, you know, doesn’t want to be monitored or have an epidural or anything else that she’s supposed to have, so I think she’s going to be a bit of a difficult customer’.

Ruth, the day shift co-ordinator raises her eyes to heaven ‘that’s all very well, but when something goes wrong, you know who they’ll be blaming’ she motions to the Consultant rota, ‘At least Miss Perry’s on for us today, and she’s her named Consultant, so maybe she can talk some sense into her’, her eyes turn towards Jo ‘and thankfully we have our tricky customer specialist on hand’ she says with a
wink at Jo, ‘see if you can get her to be a bit more reasonable will you, I could do without any drama today.’ ‘I’ll do my best Ruth’ replies Jo, as she heads off to take over Trina’s care.

Alice, the night shift midwife, explains to Jo that Trina arrived in labour about an hour ago accompanied by her husband Tom, and sister Leila. Everything seems to be going well, Trina is 38 weeks into her pregnancy, her contractions are about every five minutes, with both babies head first. ‘I’ve listened in and both heartbeats sound fine’ says Alice ‘but she won’t let me put the CTG\(^2\) monitor on so that’s about all I can do for now. The Registrar knows she’s here, but he’s been tied up with another lady, so he’s not seen her yet. I’ve already said goodbye to them, so they know you are on your way, I’m off to my bed now so hope it all goes well’. She hands Jo the maternity notes and heads off home.

Jo has cared for several women in labour with twin pregnancies before, so she is well aware of the local guidelines and the potential complications involved for Trina and her babies. Unlike ‘normal’ births, where the midwife is considered the lead professional, multiple births are considered the responsibility of the obstetric specialist, therefore, many of the decisions about how Trina is cared for will be made by the medical team and instead of leading care, Jo will be acting in more of a co-ordinating role. Jo knows that this usually works well but that it also adds another dimension to caring for Trina, as the medical team will expect Jo to care

\(\text{CTG – the cardiotocograph, an electronic machine used to monitor the fetal heart rate during pregnancy and labour and used as a tool for the assessment of fetal wellbeing.}\)
for Trina using the best practice described within the guideline and in this case, Trina is rejecting much of this guidance.

Personally, Jo is sure that she would not choose to follow the same course of action as Trina. Her professional knowledge, both theoretical and practical, means that she considers that some of Trina’s choices place her and her babies at greater risk and from the comments of some of the other midwives, it is also apparent that she is not the only one who feels this way. However, while the safety of Trina and her babies is an important consideration for Jo, at the same time she also recognises Trina’s right, as an autonomous individual, to make her own decisions, even if those decisions may be considered unusual or even unsafe by others. These conflicting perspectives place Jo in a difficult situation with responsibilities not only towards Trina but also to herself, her medical and midwifery colleagues and to her professional role. Jo reflects on how she can manage to balance these conflicting responsibilities without sacrificing her own core beliefs and while still continuing to support Trina’s right to choose for herself.

Before going into Trina’s room, Jo looks at the very extensive birth plan attached to the front of the notes which details everything that Trina would like at different stages of her labour. Jo can see that Trina’s plan for birthing her babies is very different to the care required by the guideline but that Trina is aware of this and has considered each aspect of the guideline and the risks associated with her decisions. While Trina’s previous births all took place at home, this time she has decided to have her babies in hospital, and Jo can also see that she has written ‘unless absolutely necessary’ in capital letters in several places on her birth plan. This suggests to Jo that while Trina is hoping to keep things as natural as possible she also knows things may not be as straightforward as her previous births and if it becomes necessary she may be willing to modify her plans and accept
interventions if they are really necessary. Therefore, while Trina’s choices are unusual, they certainly seem to be well informed.

Jo gathers up the maternity records and walks down the corridor towards Trina’s room. While there are many conflicting perspectives to consider, including her own, ultimately Jo’s actions are informed through reference to her own core beliefs, of what she considers to be the right thing to do. So, although Jo knows that she has a professional responsibility for ensuring that Trina is cared for safely and competently, alongside this her personal values and her vision of midwifery practice recognise Trina’s individuality and Trina’s right to make her own choices. Therefore, supporting Trina and respecting her as an individual does not require that Jo compromise her own beliefs by believing as Trina does, but simply that she is open to understanding Trina’s perspective and what is important to Trina. With this in mind, Jo knocks and goes into Trina’s room.

Several weeks later, Trina is chatting with Rachel, a friend who has come round to meet the new arrivals, George and Frederick. ‘How did it all go then?’ asks Rachel ‘I know you were a bit worried about having to go into hospital and everything’. ‘Actually it was great, much better than I expected’ replies Trina ‘of course it was good to have Tom and Leila there’ she motions over at her sister appearing from the kitchen with a tray of coffee’s, ‘they were so supportive, I don’t know how I would have managed without them, but the midwife was really great too, and I don’t think things would have been quite so easy if it wasn’t for her, don’t you think so Leila’ Leila nods and hands cups to Trina and Rachel before sitting in an armchair with her own cup ‘Yes, we were lucky to get Jo, she was really excellent’ says Leila sipping her coffee ‘she put everyone at ease straight away and seemed really keen to help Trina achieve what she wanted, and she really got Tom and me involved which I thought was so amazing’
‘Was it all pretty straightforward then, everything go as planned?’ asks Rachel.
‘Well it didn’t go quite like I expected’ replies Trina ‘I did manage pretty much everything as planned for the first one, and Georgie came out ok but then Freddie was coming bottom first and I needed a bit of help at that point, so I did end up flat on my back, legs in the air, with the monitor on and a drip to stimulate the contractions. So no, the birth wasn’t quite like I imagined it but it was still good anyway’ she laughs and smiles at Leila ‘I think I just wanted to feel in control really, and that’s what Jo did, she made me feel like what I wanted really mattered, she really listened to me and she didn’t judge my choices although it must have been difficult for her, as I know I wasn’t really doing things by the book’. ‘Yes’ says Leila ‘some of the other staff seemed a bit put out when they saw your birth plan, that first midwife seemed very annoyed that you didn’t want the baby heart monitor thing on, it was like she thought you didn’t even care about Georgie and Freddie’

Trina nods and says ‘Well, that’s why Jo was so excellent, she really knew her stuff and obviously had lots of experience but she never presumed to know what was best for me, answering all my questions and discussing everything so I could decide for myself. Even in such a short time, she really sussed me out, what was important and what wasn’t, so by the time I needed help with Freddie, I trusted her completely and knew she would only suggest what was really necessary. All in all it turned out to be such a good experience of something that could have gone so wrong and that’s really thanks to Jo. Yes, I was very lucky to meet Jo.’
8 Reflections on the study aims and outcomes

8.1 Reflections on the conduct of the study

In this chapter I discuss the design and implementation of this study, a hermeneutic phenomenological exploration of the meaning of an excellent midwife and examine the contextual factors which influenced its conduct and therefore answer for its validity or authenticity (Armour, Rivaux and Bell 2009). The study was conceived as a way to seek the perspective of women with experience of care by midwives, using an online data collection tool – Email Group Conversations - a form of modified asynchronous focus group using email as the mode of communication. Participation by service users was good and 12 women were recruited to participate in the study. It is also noted that due to the online nature of this method, one woman with experiences of midwives outside the UK also participated in this study.

Within this study I have attempted to explore what it means to be an excellent midwife, from the perspective of twelve women with personal experience of midwifery care and it is within this context that the meaning of excellence and what it is to be an excellent midwife, has been considered and discussed throughout. As has been discussed in Chapter 3, since Heideggarian phenomenology is concerned with understanding what it means to be a person in the world (Leonard 1994) and therefore, does not seek to provide a truly objective presentation of midwifery excellence, the subjective nature of this study, based on the experiences of a small number of self-selected women and set within the
interpretative background of my own professional midwifery experience is recognised. However, while the number of women who took part is small and therefore denotes an understanding of excellent midwives from a somewhat limited and personal perspective, these women’s comments do represent an important contribution to an understanding of midwifery excellence from the user perspective.

Furthermore, exploration of a new approach to collecting qualitative data online has proved useful and generated data that might not otherwise have been available. The accessibility of the virtual environment facilitated participation by women with small babies and children who might otherwise have found it difficult to take part because the asynchronous e-mail facilitated group conversations enabled women to contribute to the group discussions at times that suited their day to day lives, with many contributions made late in the evening or at night.

In addition, discussions took place over a longer period of time than might usually be expected and the group interaction also provided an opportunity for participants to explore each others views and opinions without significant direction from me as the group facilitator/researcher. Thus questions asked within the groups were those considered important by the women, and in group 2 in particular, the majority of the questions asked came from the women themselves, rather than from me. Although I had started each group with a preliminary question, and had a schedule for questions to ask during the group discussions, it soon became apparent that the women were already asking these questions of each other, as well as questions that I had not considered. Therefore, I soon abandoned the interview schedule and was led by the women’s direction.
8.1.1 Addressing Issues of Recruitment

Recruitment to the study focused on promoting the study to potential participants by advertising on appropriate websites, with a link to the study website (Appendix A), which included information about the study and its aims and also about myself as the researcher. The initial response to advertising the study on websites specifically related to mothers and babies was generally good and all the sites approached agreed to post some information on their web pages or to pass on information regarding the study website, although this did not actually happen in some cases. Two mother and baby magazine sites were particularly supportive of my study and actually provided valuable advertising regarding the study website and aims of the study.

Women service users soon started to volunteer and I was able to run three successive groups, involving 12 women. Four others in the service user category submitted consent forms confirming their interest in participating, however, when I contacted them by email they did not wish to continue further at that point. Of those allocated to a group, only one of the final participants withdrew during the course of the group discussions, citing a lack of time as the reason. There were no other problems or concerns reported regarding the email group conversation method.

There were three service user groups in total as shown in appendix F, although the number of participants in each was variable and this was simply a matter of timing as women volunteered to take part at different times. This made it difficult to allocate women to a group about to start and also caused problems when sufficient numbers were not immediately available to run a group. In future if using
this method I would aim to recruit participants within a specific time frame to avoid these issues and to try and make the groups more even. It is apparent that the women in group 2 had the most successful group conversations and this perhaps demonstrates that there should be at least 5 participants for optimum results within this approach.

8.1.2 Addressing issues of Access

Access may be limited in online studies and preclude some individuals from taking part due to their unfamiliarity with the technology involved or with lack of access to computers and online environments. This is an issue which requires consideration in the design of any research study and should certainly be considered a limitation in my own study. However, all methods represent compromise, and therefore I do not feel it has been a significant problem in the exploration of this specific topic.

Virtual focus groups (Oringderff 2004, Kenny 2005, Turney and Pocknee 2005, Im et al. 2008) and the use of email for qualitative data collection (Kralik et al. 2000, Kivits 2005, Kralik et al. 2006) have already proved useful in a range of situations and have been shown to be especially useful where participants may be unable or unwilling to attend in-person groups due to constraints of time, geography or ability. Therefore, development of Email Group Conversations for use in this study, a modified version of the virtual focus group using email communication, has been particularly useful as it provides a great deal of flexibility for participants. This is a key benefit as it supports participation by enabling women to contribute to the discussion at times convenient to their own circumstances, a feature that is vital
for those with small baby’s and children. In this study, the majority of the women submitted their thoughts, questions and answers for discussion in the evenings with many submissions made late at night, after ten pm, with some even in the early hours of the morning.

Moreover, the use of an online method has also provided an opportunity to discover a more geographically diverse opinion than would have been possible with a more traditional method and my own limited time and resources. Therefore, flexibility of participation might be seen as a major strength in this study. Most of the women involved had small babies and children, making participation in a normal focus group potentially more difficult. Arrangements for childcare, travel and the restrictions of a specified meeting time might discourage many women from taking part, in a similar way to individual interviews which also require a specific time and venue, meaning that time is still less flexible. Therefore, the use of Email Group Conversation may offer a way of improving access and enabling more flexible participation, especially where physical attendance or specific time frames are an issue.

8.1.3 Addressing Issues of safety and comfort

The anonymity afforded by online research methods has been shown to considerably increase the willingness of participants to disclose information that might not be offered in more traditional, face-to-face methods. Although the women in my own groups were offered the opportunity to choose a pseudonym to use in the group discussions, all of them without exception were happy to use their
own name. It is possible that the relative anonymity already afforded by the online environment and the protection of their personal email addresses already allowed them to feel safe. Discussions in the groups were always respectful of each others point of view, even when challenging that perspective or idea. However, it may also be that the participants felt the topic itself was something they were happy to discuss freely and which did not present a personal threat to them in revealing their ideas and thoughts, in a way that a study exploring a more sensitive issue might have been.

I did have a concern that women with traumatic experiences of birth might find it difficult when discussing their experiences and I had therefore sought advice on independent support to which women might be referred if required. In reality, my experience was that the group members themselves often provided supportive comments to women who related unpleasant or unhappy experiences during their pregnancy and birth. One participant in this study reported that she felt the discussions and comments from her fellow group members had helped her to feel more positive about her poor birth experience while another, coping with the sudden illness of a close family member, communicated with me directly through email and was able to feel supported in that way. She was very keen to remain part of her group but did not want other group members to know her personal circumstances and continued to submit her perspective whilst indicating the parts of her communication that she wished to be seen only by me and those that were for circulation to the group. The blind copy circulation format supported this particular woman in being able to discuss her problems outside the focus group while maintaining her commitment to the rest of her group.

In my own study, all messages were sent initially to me by participants, prior to circulation to the rest of the group in blind copy format (email addresses not visible
to recipients) and I was therefore able to pre-screen for any inappropriate or offensive language, although this did not actually represent a problem with the focus groups within this study. The size of the focus groups was also kept small, with the groups containing 3-5 participants to reduce the numbers of emails each participant received. It was hoped this would prevent textual overload, while allowing some flexibility for the group to still function if some members decided to withdraw or drop-out and this proved to be the case, as group members often sent in lengthy discussions for circulation within the group. The small group size may also have helped the groups in getting to know each other initially and keeping track of each other in the textual discussion format and facilitated real ‘group’ discussion and interaction.

8.2 Email Group Conversation – A review

During this study, the women were asked to discuss their understanding of the meaning of an excellent midwife within small email facilitated groups. Email Group Conversation is a method of collecting data similar in format to a focus group, but differs in that none of the women met each other except in virtual terms, and in addition, discussions were conducted at a much slower pace, lasting several weeks. In a similar way to a focus group each woman in their own particular group heard what each of the other members of the group had to say, although this hearing was in the text format of the other women’s emails. This did mean that women were able to read any questions and the other women’s contributions and due to the asynchronous method, were free to think about, compose and refine their own comments before submission.
Although there are many good reasons for choosing virtual methods, one of the most frequently mentioned concerns of using this approach, particularly in qualitative research, is the lack of face to face interaction involved. This is linked to the understanding that a principle source of data in in-person research encounters is the field log that accompanies the interview, noting contextual features such as the participants’ behaviour, facial expressions and body language during the interview to add to the context rich verbal discussion. Moreover, the researcher is physically present and sees and speaks with the participant, she hears her voice, can distinguish the tone and knows the inflection or emphasis put on certain words.

In contrast, the use of an online method means that participants are removed and anonymous, existing in the virtual world, and it is therefore argued that the additional layer of context rich description common to in-person encounters is lost. Participants are not seen by the researcher, nor are their voices heard and communication is in textual format only. Therefore, although the text can provide rich descriptions, it is not considered as spontaneous, as real, as face to face interviews and particularly with the use of asynchronous methods, such as the one used in this study, the participants experience is seen as more reflective. While these arguments are good ones, and it is true that online methods for data collection do have to answer to these concerns, my experience suggests that online methods can provide context and depth to the interview process, but in a different way.

During the course of the study, it soon became apparent that the women’s Email Conversations were providing more contextual and descriptive information than previously anticipated, which added to the richness of the data collected, adding emphasis and a deeper level of meaning. Therefore, I suggest that collecting
qualitative data online, while certainly different from more traditional methods, need not be seen as providing less robust or detailed data. While the use of Email Group Conversation can provide benefits for participant and researcher, it can also suggest new possibilities for qualitative research. The following discussion presents some of the novel ways in which the women in this study used this medium to accentuate their contributions and to bring added value to the group discussions.

8.2.1 The use of textual style for emphasis

One of the major criticisms of virtual research methods is the concern that data collected in text only format, such as the emails used in this study, will lack the nuances of emphasis that occur when the participants voice and facial expressions cannot be seen. However, many of the women’s email discussions were formulated in ways which did provide more than just the written word as is shown within the extract from Karen’s discussions on page 87.

Karen’s use of capitals within the body of her text, emphasises her feelings in a similar way to that which might have been heard in a face to face setting. It is obvious from the style of her text that Karen feels very strongly about the point she is making, and when you read what Karen has written a sense of that strength of feeling comes across to the reader. Therefore, although this conversation is taking place in a ‘virtual’ space, Karen seems present and very real.
In addition, Karen also uses a very conversational style for her writing, including the slang words ‘blah, blah, blah’, just as she might in a face to face conversation. She and the other women frequently use phrases, punctuation and layout formats to bring their written words alive and this, in combination with the way in which women ask and answer questions, in effect transforms their emails into a written conversation, rather than simply a piece of written prose.

The usual styles of written communication do not generally include the verbal slang found in oral communication formats and are usually very different. This is due to the nature of the written text, where the rules dictate that a more formal and prescriptive style is used than that found within oral communication. This is evident when spoken conversations are transferred into written text, as seen in transcriptions of verbal interview texts. When heard these conversations, with their pauses, repetitions and fill-sounds seem fluid and normal, however in writing, these conversations look clumsy, stilted and unusual.

The women’s email conversations are not like this and are much closer to spoken word. Email bridges the gap between written and oral communication as it is less formal than traditional written text and presents more flexibility, relaxing the normal rules of written communication. Of course, conventions do still apply within email and other methods of computer mediated communication (CMC). Indeed, virtual communications have their very own style and meaning units, which have developed into ‘folk dictionaries’ of commonly used phrases, such as ‘LOL’ or ‘laugh out loud’. These are used by participants as a means of adding a visual cue pertaining to the writer, alongside that of the text and for providing more social context within the group discussions. The danger with internet slang of this sort is in misunderstanding, especially with abbreviations that may not be commonly known and used.
The way in which text is written also provides clues about women. Some of the women had obviously spent time carefully considering and crafting their email, where the grammar, language and spelling showed attention to fine detail, while others were more spontaneous and included spelling errors and missing fill words. This suggests that some women used the opportunity to reflect on and consider their responses while others were more spontaneous with their contributions. Therefore, although it has been suggested that online studies, particularly the asynchronous variety reduce the spontaneity of participant’s responses, this does not mean spontaneity cannot exist at all. An example of this is shown by Karen who sent an additional email only a few minutes after her previous one, addressed as ‘PS’ and providing a follow up comment. This follow up email would certainly suggest that Karen is writing spontaneously, at least for part of the time.

8.2.2 Including visual information

Collecting qualitative research data online also provides participants with other ways of expressing themselves and supporting their opinions and ideas. Email, as well as being a simple and easy to use method requiring no special software over and above what participants many already have, also allows for other items to be sent alongside the email in the form of an attachment. Nadine chose to send a cartoon (see page 80) with one of her contributions to highlight the point she was making about midwives needing to be led by what women want, rather than by what midwives might think they want.
The opportunity to add visual information such as this is rarely used in face to face contexts but online methods do allow for individuals to be more expressive in how they choose to represent their views and therefore, the control of how information is presented is not wholly in the hands of the interviewer. Women also use other pictorial references such as emoticons to express their feelings and as a way of providing the social communication found in a face to face group, like laughing at another group members joke or expressing agreement with a point that someone else had made.

8.2.3 Group interaction and discussion

Email Group Conversations is a modified version of the more commonly used focus group discussion, asynchronously facilitated using normal email, and circulated amongst group members so that each one has the comments and questions posed by the other members of the group. One of the main prerequisites of a traditional focus group is that the interaction between group participants can be seen. While not a focus group in the traditional sense, the Email Group Conversations did provide a lot of group discussion particularly within group 2. The written conversations took place in much the same way as they might in a face to face discussion, for example, members of the group answering questions asked by others in the group, posing new questions and clarifying information, with phrases like ‘I am not sure if I understand’.

The women taking part in the groups usually addressed comments to individuals by name and asked questions to clarify points that had been made, or answered
questions using a conversational style similar to what might be found in a normal face to face situation. In contrast, they sometimes wrote in a format unlike normal conversation, using their email to make comments about a number of discussion points at the same time while maintaining the individual address style.

Another form of communication seen within the group discussions was in the form of summation. Some of the participants considered the comments of the other group members and then presented their own summary of the groups feelings, using phrases such as ‘we all seem in agreement’, before going on to ask a new question. This allowed for clarification of others ideas and opinions and gave group members the opportunity to see what others had understood from their comments.

While the group discussions started with an initial question and there had been an intention to ask further questions as the group progressed, the participants in the groups, particularly in group 2, tended to raise many of their own questions and frequently asked each other for clarification on specific points. This meant that the discussion progressed amongst the group members with minimal input from me, perhaps suggesting that they were able to explore the topic with more of a client-centred focus, asking questions and raising points of interest that I might not have considered asking. Groups 1 and 3 did require more interaction from me in the form of clarifying questions, and their discussions did not take place over such an extended period, as those in group 2. However, the participants in each group seemed to consider themselves part of a group discussion, with some even commenting that they enjoyed the exchange of ideas and looked forward to hearing what everyone had to say.
Overall, reflection of recruitment and participation within this study highlighted a number of issues, the majority of which are related to my decision to seek participants and to collect my data using computer mediated communication methods. Undertaking a study in a new environment, using new technology with new approaches to collecting information is in itself a steep learning curve. In addition, as a relatively new researcher, I made mistakes and therefore learned along the way.

Time was also a major feature. As a practicing midwife, working full time within the NHS environment and with limited time and resources, the scope of the project was limited by necessity. However, Email Group Conversations as a simple technique for online asynchronous group discussions, proved to be very useful as it allowed me to communicate with women over a number of weeks and was not time specific, fitting in to my busy work schedule in much the same way as for the women involved. It also meant that the women’s discussions were already in text format, which saved time in transcribing the discussions.

However, while virtual research methods may have benefits in some areas, the use of online methods for the collection of qualitative data requires careful consideration to ensure that it is fully compatible with the research aims. Furthermore, since personal contact is limited, the methods used to instigate initial contact, such as the study website which I used, requires careful design and development. In my own case, the study website required considerable time and for someone who started as a novice, also required learning a lot about website design along the way. In addition, facilitation of the Email groups also required
new skills and approaches and I found that the introduction phase of the group was especially important, as women taking part only had the written descriptions of their fellow group members.

This was a problem in the first group, where I subsequently realised that I should have started the group with some social questions, as I did in the following groups, rather than starting off with the first question. The missed opportunity to develop a group identity amongst the members of this group meant that the discussions were more stilted and less interactive than in the following ones. One group member did elect to withdraw during the course of this group, the only one of the service users who did so, and although she cited a lack of time as the reason, it may also have been related to the lack of social cohesion felt within the group. Therefore, starting the group with general social discussions such as a short introduction from each participant telling the others a little about themselves is important to ensuring that the conversational aspect of the email discussions is developed.

However, overall the use of Email Group Conversations within this study has provided rich data regarding women’s experiences of excellent midwives. It has also provided an opportunity to develop a new approach to communication with women service users and may ultimately be useful within the practice environment to support user involvement and promote user feedback.
Excellent Midwives

9.1 Excellent Midwives – Excellent Individuals

The purpose of this study has been to discover more about what it means to be an excellent midwife, through exploration of the perspective of 12 women maternity service users with experience of midwives whom they considered to be excellent, within a hermeneutic phenomenological approach based on the philosophies of Martin Heidegger and Hans-Georg Gadamer. What it contributes is an understanding of excellence as an intrinsic feature of the individual, grounded within each midwife’s moral beliefs and values and described as a way of ‘being’ a midwife that comes from deep within the individual themselves. The women in this study consider this the key feature of excellence, something that an individual possesses at a very personal level and one which is brought to midwifery practice rather than taught or instilled during professional education.

Excellent midwives are considered to be excellent individuals who bring excellence in being to their professional role and are described as possessing a combination of intrinsic moral virtue, authenticity in their professional role and a disposition towards caring. This blend of being, knowing and showing is represented by the moral compass (page 134) an original conceptual metaphor used to illustrate how these fuse to support the midwife in maintaining her belief in birth, women and midwifery within the dichotomous environment of modern midwifery practice. Consequently, individual excellence might be understood as a foundation that excellent practice is built upon, the midwife’s moral identity at the core of her being, impacting on all areas of her practice.
This is an interesting consideration because it suggests that an understanding of excellence as existing within the midwife herself, rather than to a specific context or model of midwifery practice, allows for the possibility of excellence within any sphere of practice. This could have a significant impact on many women’s experience of pregnancy and birth particularly within institutional environments of birth such as the NHS.

Furthermore, while the women’s discussions have provided the basis for a new interpretation of midwifery excellence, one based on the midwife herself, the development of a new approach to online group discussion, Email Group Conversation, has also proved beneficial. Email Group Conversation contributes a new experience of qualitative enquiry within the virtual environment whilst also challenging previous perceptions about the use of group methods within qualitative research. In addition, it encourages an expanded consideration of what constitutes data in phenomenological research, providing participants with an opportunity to express their experience in new and different ways.

9.2 Implications for practice and suggestions for further work

Although this study represents the views of a small group of self-selected women service users whose own personal experiences provide new insight into understanding midwifery excellence, it is only one interpretation amongst many possibilities. Therefore, it would be useful to further this exploration amongst other groups of women and amongst a wider range of maternity professionals, to
consider if the individualistic nature of excellence postulated within this thesis is a feature of excellence when taken from other, different perspectives.

The concept of excellence as connected with an individual, rather to a specific model of practice, also raises a number of other exciting possibilities for exploration. Such an individualistic approach to excellence suggests that we should perhaps look more closely at the midwives within different models of care to consider if it is the type of care being provided or the individual midwife themselves that makes a difference to women’s experience. This may have the effect of supporting different ways of working and of placing more value in the caring practices of individuals, in whatever environment they work. It might also provide an answer to the current problems associated with midwives being seen as generally more professional and less caring, as suggested by the women in this study.

An understanding of excellence as central to practitioner themselves, rather than to a specific model of care or sphere of practice is also interesting from a service perspective because it has implications from two very distinctive directions. Practitioners driven by an inner focus towards excellence derive emotional reward from their ability to act for the good of others, rather than relying on emotional reward in the form of feedback from others. This means that excellent midwives may demonstrate more emotional stability and resilience to the stresses and complexities of the practice environment. The result of this is two-fold – firstly that they are therefore more emotionally available to the women for whom they care, improving communication and making women feel special and listened to and enhancing women’s experiences of maternity care, improving quality and potentially reducing complaints. Secondly from a workforce perspective, midwives
who have more emotional resilience may have better coping mechanisms and thus reduced rates of sickness caused by burnout or stress.

A view of excellence as something which develops and exists within the individual and is brought to midwifery practice might also have significance for how midwives are selected and educated. This study suggests that excellence comes from within the individual and is related to a desire to care about others, self awareness and the motivation to become a better person, and thus ultimately, a better midwife. Although such virtues were previously valued within the more vocational context of midwifery, they may have fallen out of favour within the more academic milieu of midwifery education and practice. However, since it would seem that women judge midwives largely by their caring attitudes and behaviours, a stronger focus on this aspect within professional education would be a valuable addition to any midwifery educational programme. One way to address this problem could be a focus on the development of personal philosophies of midwifery practice, perhaps using the moral compass as a model to help practitioners consider how their own ways of ‘being’ impact on and affect the way in which they care for women, alongside the more technological and academic aspects of their development.

The moral compass model might also be useful tool for encouraging midwives to consider their ongoing philosophies of care during their annual supervisory review. for ongoing development amongst midwives and could be incorporated w, as it is a model which encourages reflection, constant re evaluation and development of new ways of living in the world. Therefore, it might be used to help midwives consider their underlying motivations and experiences during on going professional education, as part of the supervisory review and as part of the recruitment and selection process.
Finally, this study itself will hopefully get midwives thinking, stimulating debate and perhaps encouraging individuals to consider how their own ‘being’ affects the women for whom they care. Therefore, I plan to try and publish this work and to present the findings amongst my peers and colleagues. I also hope to have the opportunity to investigate some of the new and interesting ideas which have been revealed alongside a deeper understanding of midwifery excellence.

9.3 Conclusion

The understanding of excellence advanced within this thesis suggests that excellent midwives are excellent individuals who bring excellence in ‘being’ to their professional role. This forms a foundation from which excellent midwifery practice develops. Professional knowledge, skill and experience are important, but at the heart of excellence is a desire to be a better person, and therefore a better midwife. As a practitioner, I also hope to become a better midwife, embracing what it is to ‘be’ an excellent midwife.


Berg, M. & K. Dahlberg (2001) Swedish midwives' care of women who are at high obstetric risk or who have obstetric complications. *Midwifery*, 17, 259-266.


Tonks, A. (2002) What is a good doctor and how can we make one? British Medical Journal. bmj.com/cgi/content/full/324/7353/DC1 (last accessed.


Appendices
Welcome - this website is part of a research project which aims to discover the meaning of excellent practice in midwifery. The site has been designed to let you know what this research is for, who the researcher is and how you can volunteer to take part and tell me your views.

It is important that you read and understand your role as a participant in this research and what would be expected of you if you were to volunteer. You can find all this information and how to contact the researcher by following the link below on 'What is the role of participants'.

Visiting and reading these pages does not enter you into the research study - when you have decided if you would like to take part, please follow the link below 'How can I take part'

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The Meaning of Excellent Midwifery Practice
- a research study to discover what excellent clinical practice means to you

Why should we research this subject?

The word 'excellent' is commonly used within our healthcare systems today with users promised excellent clinical care and practitioners asked to strive to develop excellent clinical practice. However, at this time, there exists little theory by which to judge if excellence in clinical practice is really being achieved.

In addition, in the United Kingdom, technical skills and competency are currently receiving a high profile in the NHS (National Health Service) with the introduction of the Knowledge and Skills Framework (Department of Health 2004). Although no one would argue that competency is very important and a basic requirement for any practitioner, is 'competent practice' the same as 'excellent practice'?

The Government has included the principle of 'excellent practice' at the core of its drive to update and improve the services of the NHS, however there is widespread disagreement within the published literature about what this really means. At the moment, within the professional literature, excellent practice is usually described as being shown in the practice of expert or specialist practitioners alone. Most important of all, the views of what healthcare users want and expect from practitioners and services within the NHS to demonstrate clinical excellence is largely unknown.

This research project has been designed to explore the meaning of 'excellent' clinical practice in midwifery with groups of healthcare users, health professionals and professional organisations with the aim of building up a robust multi-perspective theory of excellent practice.

A better understanding of what 'excellent practice' really means to healthcare users and practitioners could be used to enable practitioners to develop their practice in a meaningful, patient-focused way.
This information is provided to help you decide if you would like to take part in this research project. You should read all the information carefully before deciding if you wish to take part. Participation is voluntary.

You are under no obligation to take part - visiting and reading the information on this website or contacting the researcher for further information does not enter you into the study.

After you have read this information and decided if you would like to take part or if you have any further questions you would like to ask the researcher, please visit the section 'How can I take part'.

What is the role of participants?

In this research study I would like to find out what the words 'excellent practice' really mean. To do this, it is important to ask lots of different people what they think it means, because different people may have different ideas of what 'excellent practice' should be. All these individual ideas will then be combined together to develop a theory that describes what 'excellent practice' means. I hope that this theory will then be used to help health care workers improve the care that they give.

As a participant you will be contributing to developing this theory by discussing your thoughts about 'excellent practice' in small groups (focus groups) over a number of weeks, using e-mail. The e-mail discussions will be facilitated by the researcher, who will help each group to develop their own idea of what they think 'excellent practice' means. The ideas from the focus groups will then be fed back to all the participants to develop a final combined theory.

Anyone can take part in the research, you don't need to know anything about theory development as the researcher will support this. All you need to do is read the ideas that other people in your group have, and send in your own ideas for them to read and comment on.

What would I have to do?

To take part you need to have access to an e-mail account and to have your own e-mail address. The discussions are likely to take place over a number of weeks, so you should be able to check your e-mails at least once a week during this time. Reading other group members comments and replying should take you about 15-30 minutes once each week. It does not matter what time of day or day of the week you check your e-mail or reply.
You must also agree to abide by some basic rules of 'netiquette' while participating in the study. At the end of the study all participants will be sent a summary of the results. To volunteer to take part just follow this link or the one below.

**Are there any risks or benefits in taking part?**

There are no benefits to you personally but your participation will help develop a theory that could help health care workers to improve the services they provide. You can contact the researcher at any time if you have any concerns.

Participation is entirely voluntary and you have the right to withdraw at any time, however you should understand that if you choose to leave the study, the information you have already provided cannot be removed from the study, although your participation would stop. If you do not make any reply to your focus group discussion for two weeks, the researcher will send one e-mail to you asking if you still wish to continue to participate. If no reply is received you will be considered as having withdrawn from that group and from the study.

The researcher will do everything possible to maintain your confidentiality and the study itself has been designed to minimise the risks of breach of confidentiality, however, because this is an online study, absolute confidentiality cannot be guaranteed. You should be aware before you agree to participate, that, as with any other online communication, your e-mails may be open to unauthorised interception.

Your personal details and e-mail address will not be shared with any other participant. All e-mails will be sent initially to the researcher and then circulated to the focus group in blind format. This means that none of the other focus group members will know your personal e-mail address. You can also choose to remain anonymous within your focus group by using a pseudonym or identification of your own choosing, in which case only the researcher will be aware of your real identity.

At the end of the research the theories developed, comments and quotes made will be used to explain the theory and its development. These will all be kept anonymous, that is, no one will be able to tell who made those comments or quotes. Information collected during the study will be stored in a locked cupboard accessible to the researcher and her research supervisor only. At the end of the study all e-mail addresses and personal information will be destroyed.

If you have any concerns over the way the research is progressing you can contact the researchers supervisor by following this link.
About the Researcher

Hello, my name is Carol Bell and I am undertaking this research as part of a Professional Doctorate in Health and Social Care, part-time, with the University of Brighton.

I am a Registered Nurse and Midwife and am currently employed full time within the NHS as a Practice Development Midwife.

My role means that I support health care workers in my department (maternity) to develop and improve their practice. I am also involved in helping to identify areas of clinical practice that we can improve.

Understanding more about 'excellent' practice, could help me to better support other health care workers and improve the development of services to meet user needs. I would also like to publicise the results of the research so that other health care practitioners can benefit from your discussions.
How can I take part?

When you have read all the participant information and decided that you wish to take part in the research study please complete the online study entry/consent form below and send it to the researcher. The researcher will then contact you by your chosen e-mail.

If you have any questions and would like to discuss them further before you decide that you want to volunteer to take part, please follow this link to contact the researcher by e-mail. You will not be entered into the research study until you have submitted a completed online study entry form.

This research has been reviewed and approved by a NHS Research Ethics Committee.
Consent Form

First Name

Last Name

Age (years)

Your e mail

Are you (please choose appropriate)

Health Care Worker

Non Health Care Worker

To complete the consent form please read and check the following and press submit

1) I confirm that I have read and understood the information provided on this website and have had the opportunity to contact the researcher to discuss any unanswered questions

2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without my legal rights being affected

3) I give consent for the researcher, Carol Bell, to contact me using the e mail address of my choice

4) I agree to take part in this study

Submit

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11.2  Appendix B – Example Transcript

<table>
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<tr>
<th>Participants Transcript Example</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 2 - Heather</strong></td>
<td></td>
</tr>
<tr>
<td><strong>H 19/04/2006 2154 hrs</strong></td>
<td></td>
</tr>
<tr>
<td>1 I had both my children in hospital and both midwives were excellent, respected</td>
<td></td>
</tr>
<tr>
<td>2 my wishes and assisted as necessary.</td>
<td></td>
</tr>
<tr>
<td>3 My first birth was really straight forward but my second was a little more</td>
<td></td>
</tr>
<tr>
<td>4 complicated.</td>
<td></td>
</tr>
<tr>
<td>5 I had to be induced two weeks early due to obstetric cholestisis.</td>
<td></td>
</tr>
<tr>
<td>6 Not the most pleasant of experiences as each procedure was not taking the full</td>
<td></td>
</tr>
<tr>
<td>7 effect.</td>
<td></td>
</tr>
<tr>
<td>8 Then on the early shift along came Clare.</td>
<td></td>
</tr>
<tr>
<td>9 She was confident, instilled a sense of knowing what she was doing and started</td>
<td></td>
</tr>
<tr>
<td>10 to take control and get things moving.</td>
<td></td>
</tr>
<tr>
<td>11 It took the top dose of drugs to start the contractions and during them the baby</td>
<td></td>
</tr>
<tr>
<td>12 was not happy with various positions, so Clare put me in a position that was</td>
<td></td>
</tr>
<tr>
<td>13 happy for baby if not the most comfortable for me.</td>
<td></td>
</tr>
<tr>
<td>14 She continually monitored both of us, kept my husband happy and occupied, had</td>
<td></td>
</tr>
<tr>
<td>15 a sense of humour yet she was not obtrusive</td>
<td></td>
</tr>
<tr>
<td>16 But one thing I did note she was clinically correct on all her predictions.</td>
<td></td>
</tr>
<tr>
<td>17 She said the baby was face up and it appeared that way, she said the cord was</td>
<td></td>
</tr>
<tr>
<td>18 wrapped somewhere and it was, twice around the baby's feet and hands, she</td>
<td></td>
</tr>
<tr>
<td>19 knew when to offer help and when to step back and let me get on with it.</td>
<td></td>
</tr>
<tr>
<td>20 Plus she spotted that I had a very rare placenta and whisked it off to show to</td>
<td></td>
</tr>
<tr>
<td>21 everyone the photographed it for teaching purposes!! (All with my permission!)</td>
<td></td>
</tr>
<tr>
<td>22 All in all it was such a good experience of something I felt could have gone so</td>
<td></td>
</tr>
<tr>
<td>23 wrong and that was made possible by the midwife's competency and skill.</td>
<td></td>
</tr>
<tr>
<td>24 That being said, within the community I have had a different experience with two</td>
<td></td>
</tr>
<tr>
<td>25 community midwives that shared our GP practice.</td>
<td></td>
</tr>
<tr>
<td>26 One was confident, very chatty and instilled that in you making it seem that all</td>
<td></td>
</tr>
<tr>
<td>27 was ok.</td>
<td></td>
</tr>
<tr>
<td>28 The other could only be described as a bit 'dippy', quiet and not always looking</td>
<td></td>
</tr>
<tr>
<td>29 like she knew what she was doing.</td>
<td></td>
</tr>
<tr>
<td>30 However, this midwife, always got it clinically right with my pregnancies and</td>
<td></td>
</tr>
<tr>
<td>31 always referred me to the hospital if I had any problems.</td>
<td></td>
</tr>
<tr>
<td>32 The other midwife, although confident, did get it wrong on a few occasions</td>
<td></td>
</tr>
<tr>
<td>33 (trying to tell me my urine infection was grazes and the position of the baby was</td>
<td></td>
</tr>
<tr>
<td>34 not correct).</td>
<td></td>
</tr>
<tr>
<td>35 So you can never tell, and we should always look a bit deeper than the chat!</td>
<td></td>
</tr>
<tr>
<td>36 Hope this is helpful, looking forward</td>
<td></td>
</tr>
</tbody>
</table>
Hi Carol

Thanks for sending the comments from the others. It is tricky isn't it, it appears that we are all individuals and all have different expectations with things. Some people read into everything, ask all the right questions and generally get the responses they require. It appears the sample of ladies on our 'chat circle' are passionate about having it right, can make informed decisions based on the knowledge they receive and know how to get it right for themselves.

However, what about the timid ones, the not so clever ones, the people who have high ideals and are let down badly when it does not quite go according to plan? The other point is the midwife themselves. It is obvious it varies from person to person and that begs the question is it the training or the person's character. Ongoing development is always good but for some people we could train them forever and they may never get it just right! And who tells them, us, their manager? And should we expect the individual to go beyond the call of duty and not get paid for it, should we survive on good will? Which brings me back to my thought that I think for some people caring, listening and intuition comes naturally before skill and competence and that is what counts. I hope this is not too much of a ramble, sorry about the delay in responding to you, I had the relatives over this weekend for the Christening of my daughter (which went really well and was lovely)

Best Wishes

H

Hi Carol

Some very interesting points from the other two ladies and I agree it is about what people want and to be listened too. But again how is that achieved, do we listen to what women want to get excellent midwives or do we train midwives to listen to what women want. It is a bit of a chicken and egg situation. Core Values are hard to define, they could be set out in guiding principles, guidelines, code of conduct, but again it comes down to the individual, do we look for these core values when recruiting but then again with a shortage of clinical staff do we go for the nearest thing and then hope we can train them to the our core values and then how do we monitor (and who monitors) this whole process. Also I believe (and I know this is not the view of everyone) that we are extremely lucky to have the NHS, the scanning, monitoring, tests and after care is extensive and intensive. This is a time pressure for some midwives with large case loads. And then there is always a few who are never happy no matter what you do!!!! Looking forward to hearing from you again
Hi Carol

Some very interesting comments and a lot of agreement in what is being said.

To answer SG, I do not think there is an answer and in some ways you explained it yourself.

One is as important as the other but as I said in last comments is it chicken and egg how do we get midwives with skill competence and able to be caring, listen and intuitive.

Can we train people to have all those skills, do they need them first, can they learn them, if they cannot learn/train how do we then continue to employ/use them.

Does it come down to vocation or just another job.

Could performance be monitored against agreed standards?

I agree with KS, this is about being a consumer/customer and we should expect a level of customer service.

Big businesses achieve results by listening to what the consumer wants and delivering (for want of a better expression!!!) that accordingly, if they do not they go out of business!

I know this is not likely to happen in the circle of life but perhaps we need more of a customer/consumer relationship.

Perhaps a contract is needed at first consultation between midwife and mum to be to ensure both know what the expectations should be, what will happen during the pregnancy and how care will be given.

I know some people have talked about horror stories and how awful midwives have been, but I have also heard some stories about voluntary organisations relating to childbirth telling mums to be that all they will need in labour is a Tens machine and labour is power and they should use it when giving birth.

Are mums to be getting conflicting stories or being led up the wrong path.

Midwives really know the reality of birth and all that can go wrong so is a little knowledge a dangerous thing or is ignorance bliss and if every experience different who do we listen to?

other mums, trained volunteers or our qualified midwife?

I think that is all my thoughts for now, looking forward to hearing what others have to say.

Hi Car

So very sorry for not responding, time has rushed ahead of me and it was only when I got this email did I realise I had not responded to the last one, so apologies and I hope it has not messed things up for you!

Comments on the previous email 25th May

Again, many people have some great comments.

It is true that there are systems, policies and procedures and guidelines in place and a governing professional body but who has set all the rules and regulations is it actually the people?
who need and use the service or people who think they know what we need!
We would all love excellence maybe if we are listened to that may help.
I wrote to the hospital after my experience and received very positive feedback,
encouraging and makes you think the top managers are listening (hopefully).
However, we hear every day about the pressures the NHS is under and I wonder how
long can some services be sustained.
As already been commented several birthing centres are being closed and if it takes
two midwives to have a home birth and only one to have a hospital birth, how long will it be
before we are all edged towards hospital.
We should praise the good midwives more and build on their good practise, hopefully
ensuring those not making the mark, soon realise this and buck up their ideas!
In answer to SG thinking a contract is too extreme, maybe that was not the correct word,
more a bit like a birth plan, maybe an ante natal brief about what you wish to happen and
what
they will do to help you during your pregnancy.
I do hope this is not too late and useful to others, looking forward to hearing more
Best wishes
HG
SUSAN

When I got pregnant with my daughter I didn’t need to make a decision about where to have her, I’d known from 7 years old that I wanted to give birth at home. At this age, I watched my niece being born at home in a birthing pool and from then on I couldn’t imagine any other way. I was lucky enough to book with an independent midwife and went on to have a fantastic drug-free water birth. The memory of my experience is a beautiful one that I will always treasure, there is nothing I would have changed.

To me, excellent midwifery, is all about choices and providing women with the freedom and knowledge needed to decide what is right for them. For myself, this labour was the best I could possibly have, yet I am also perfectly willing to accept that it could sound to another woman like their worst nightmare. Midwives can’t be trained in how to give the best care for every woman as each individual’s needs will be different. However, they can be trained in communication skills which will help them to listen to their clients values and particular needs.

My labour was such a beautiful experience (though painful) that when I listen to a woman who’s memories are of a real nightmare (that could often have been prevented) I feel sad, angry and incredibly frustrated. What’s fundamental is that the midwife respect the woman and be guided by her values, and also that they are not rude. This may sound obvious but I know of one young mum of 18 who was told to ‘stop making such a fuss’ during labour because if she’d kept her legs shut she wouldn’t be in this pain.
With Eve it was wonderful to know I would be consulted on every aspect of my pregnancy and labour. All women are individuals, we all have different body shapes, different values and opinions and different pain thresholds! It is ridiculous to assume that what is best for one woman is also right for another. Eve always stayed true to her word, even during my long and tiring labour. At no point did she presume to know what was best for me. She asked me when she wanted to do anything, explaining properly and giving me time to decide. It is my view that every woman should receive this standard of care.

KATE

My pregnancy and birth was an all round nightmare, but out of the 16 midwives I came across, only one stood out to me. I met 13 midwives when I was in labour. I saw three shifts come and go. Apparently I was supposed to have someone with me in labour but I was mainly left alone with my husband. My experience of excellent midwifery was when a young midwife came on the night shift. Apart from her break, the midwife stayed with me the whole time. She told me what was going on with the hormone drip, what the monitor was for, she read my plan, answered my questions no matter how stupid, suggested ways to help myself, really reassured me. She responded as soon as she thought something was wrong and held my hand during my epidural before I went to theatre. I think the overall thing here is that she gave me her time and her knowledge and reassured me during a very scary experience.

We are all individuals and have varying degrees of need and I think sometimes it can be hard for midwives to meet all of the needs. I do believe it takes a special person to work in this environment/role and it is a physically and mentally waring job. I think if any of the midwives involved with me knew how I felt about my
experience I'm sure they would be disappointed. I think we all agree its not necessarily what the midwives did for us, its what they said, how they treated us and how they interpreted our needs.

HEATHER

I had to be induced two weeks early due to obstetric cholestasis, not the most pleasant of experiences as each procedure was not taking the full effect. Then, on the early shift along came Clare. She was confident, instilled a sense of knowing what she was doing and started to take control and get things moving. It took the top dose of drugs to start the contractions and the baby was not very happy about it. Clare continually monitored both of us, kept my husband happy and occupied, had a sense of humour and yet she was not obtrusive and she was clinically correct with all her predictions. She knew when to offer help and when to step back and let me get on with it. All in all it was such a good experience of something I felt could have gone so wrong but was made possible by the midwifes competence and skill.

We are all individuals and all have different expectations. Midwives differ – it begs the question is it training or the persons character – is it nature or nurture? My feeling is that some people could be trained forever and never get it right, and who tells them? Is it us, or their manager? For some, caring, intuition and listening comes naturally before skills and competence and that is what counts.

It’s really about what people want and to be listened to. How is that achieved – through core values? Core values are hard to define – guiding principles, guidelines, codes of conduct but again it comes down to the individual. How do we monitor them (and who monitors) this whole process? Its true there are systems
and a governing professional body but who has set all the rules and regulations – is it actually the people who need and use the service or is it people who think they know what we need? We would all love excellence, maybe if we are listened to that may help.

HAZEL

As I never had a birth in hospital I can’t compare my labour to another one, but I’ve been told by many ladies that you barely get one midwife attending to you, so to have two fully focusing on me, I was lucky. Personally I don’t think I was lucky, I thought all women had two midwives. Call me gullible but I thought it would take more than one person and my husband to deliver my baby. I also got reactions like ‘they even helped you into the bath after!’ in totally shocked surprise because once they had given birth they were simply wiped clean and wheeled to a ward. People asked me if my midwives were private after my labour because they actually cleaned my bedroom up, stayed for a cuppa and even posed for photographs with my daughter. They couldn’t have been nicer, but deadly professional when the time was upon us. It was the little things that made me feel better, like explaining when there was mec in the water, rubbing my back and assuring me I was doing well. Sometimes small things make the whole difference as to how you view your midwife when you are in labour.

A great midwife is one that is willing to go beyond the call of duty to help reassure and comfort you no matter how trivial your problems or concerns may be. They are more approachable and never seem too busy to spend that extra bit of time being friendly and informative (even if their job seems never ending). The midwives I came into contact with listened and understood the exact type of birth I wanted and seemed just as keen to help me achieve it. They kept my care informal,
although at the same time were very professional. They were attentive to detail and very informative.

KAREN

I had an independent midwife and what was excellent about her was that she listened very well to me without judging and by the time labour arrived she had totally sussed me out, what was important, what wasn’t and I trusted her totally. The best example of this is when I called her to tell her I thought ‘this was it’. She just said ‘lovely, that’s great, I’ll see you in about ¾ of an hour’. It made me feel confident and trusted. That really contrasted with my other two births. You phone to say you are in labour and its like they don’t believe you. They don’t care how you feel, its just how far apart are the contractions, blah, blah, blah. You’re talking to a stranger and they are testing you. If a woman phones the hospital because her labour is starting, she’s phoning because she needs some midwifery support, even if she is only 1cm dilated and not in established labour. To be dismissed offhandedly puts you in the position of being the silly little girl facing up to the ‘expert’. I took that approach for granted until I had the experience with my IM. She knew I needed her, so she came. End of story.

A midwife sees ten of births a year – possibly hundreds in her career. Pregnancy and birth and the post natal period are her bread and butter. I think its often forgotten that this may be the woman’s only experience of it – or at least an experience that’s not likely to be repeated more than once or twice. The two look at it with very different eyes: for the pregnant woman this is something unique and wonderful, possibly scary and daunting, but a time when she feels special. The midwife sees yet another pregnant woman asking the same old questions, and
forgets the specialness or the feelings that go along with being pregnant and having a child.

I find it very hard to think about the meaning of an excellent midwife without thinking about some very poor examples I’ve heard or witnessed. They seem to be tied in with forgetting that it’s a really special thing that a woman is going through, something she will remember for the rest of her life. I was at a home birth recently where there was an absolute witch of a midwife – it struck me, that even after the baby was born, and all was well, she wasn’t able to congratulate the new parents, comment on how well she’d done or anything. This was a first time mum who had a home water birth despite the nastiness of the midwife. I think in an ideal world, I’m asking midwives to put the woman’s needs before their own. Note ‘ideal world’, of course this doesn’t happen often. But when we meet midwives who do that – who make us feel really special and listened to – you realise what the gold standard of maternity care is.
Appendix D – Schematic of individual, group and cross group data analysis
Appendix E – Diagram of theme development

| 'caring, listening and intuition comes naturally' | 'varies from person to person' |
| 'some midwives and ladies clash' | 'it comes down to the individual and their personality' |
| 'I don’t think it’s just about skills' | **Character and Personality** |
| 'a midwife sees tens of births a year' | 'does it come down to vocation or just another job' |
| 'believes in natural birth….with her whole being' | 'appreciate the individuality of birth’ |
| ‘forgetting that it’s a really special thing’ | **Belief in the Specialness of Birth** |
| 'did not presume to know what was best' | 'what’s fundamental is that the midwife respect the woman’ |
| 'its what they said, how they treated us’ | 'I trusted her totally’ |
| ‘feeling special and listened to’ | ‘feeling trusted by our midwives’ |
| | **Respect, Trust and Value** |
| | | **Moral Being** |
| 'all women are individuals’ | Equal but Different |
| ‘working ‘with’ rather than doing ‘to’’ | |
| ‘consulted on everything….given time to decide’ | |
| ‘should never dictate…. but instead empower’ | |
| ‘dismissed offhandedly’ | Controlling or Supporting |
| ‘aren't obliged to divulge information’ | |
| ‘tell women what they are ‘allowed ‘ to do’ | |
| ‘pushed in your face’ | |
| ‘answered my questions no matter how stupid’ | |
| ‘in a perfect world’ | The Real versus Ideal World |
| ‘I think in an ideal world’ | |
| ‘putting woman’s needs first’ | |
| ‘NHS does not have sufficient budget’ | |
| ‘never seem too busy’ | |
| ‘I was lucky to have a wonderful birth experience’ | |
| 'midwives do have a huge caseload' | Making Allowances |
| 'pressure must be unbearable at times’ | |
| ‘not the individual but in the hospital policies’ | |
| ‘midwives not properly debriefed of their own experiences’ | |
| 'people asked if my midwives were private'  | Expectations of the Professional Role |
| 'couldn’t have been nicer but deadly professional' | |
| 'how do we get skill and competence and able to be caring' | |
| 'it was the little things that made me feel better' | |
| 'they should be knowledgeable'  | Theoretical Knowing |
| 'too much information can be a negative thing' | |
| 'means being well up on current research' | |
| 'its ok reading it in a book, but words are better received' | |
| 'experience may be a factor'  | Authentic Professionalism |
| 'hard to trust a newly qualified midwife' | |
| 'reassured by the knowledge that Eve had years of experience' | |
| 'personal experience a hotly debated subject' | |
| 'may become desensitized' | |
| 'well trained to handle emergency situations'  | Embodied Knowing |
| 'always got it clinically right' | |
| 'too much emphasis on technology... taking away from the skills of the midwife' | |
| 'too much information can be a negative thing' | |
| 'means being well up on current research' | |
| 'its ok reading it in a book, but words are better received' | |
11.6  

**Appendix F – Group Demographics**

<table>
<thead>
<tr>
<th>Identifier and group</th>
<th>Personal information</th>
<th>Age range</th>
<th>Birth/Midwife Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 – four participants</td>
<td>All non health care workers</td>
<td>30-45 years</td>
<td>2 Hospital births – NHS Two pregnant</td>
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<tr>
<td>Nina, Vicky, Sophie and Jenny</td>
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<tr>
<td>Group 2 – five participants</td>
<td>4 non health care workers, one trainee NCT teacher 1 mental health nurse</td>
<td>21–35 years</td>
<td>2 Hospital births and 3 home births – NHS and Independent Midwife</td>
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<tr>
<td>Kate, Karen, Susan, Hazel and Heather</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Group 3 – three participants</td>
<td>2 Non health care workers 1 nurse non maternity</td>
<td>25–29 years</td>
<td>One currently pregnant (Canada) 2 Hospital births – NHS</td>
</tr>
<tr>
<td>Nadine, Sara and Tania</td>
<td></td>
<td></td>
<td></td>
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