

**A descriptive phenomenological study of
independent midwives' utilisation of intuition as an
authoritative form of knowledge in practice**

By

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Abstract

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Out of the diversity of possible ways of knowing in maternity and health care, there has emerged a hegemonic emphasis on knowledge that is based on scientific principles. Arguably, there is also a role for intuition in healthcare. Indeed, leading midwives, educationalists and researchers in related fields have hailed the important role of intuition in advancing midwifery practice and education. A review of the literature shows that there is a dearth of research exploring the nature and use of intuition in midwifery practice. This descriptive phenomenological study explores the experiences and use of intuition in a cohort of seven independent midwives across the South and Midlands area of the United Kingdom. The study explores what midwifery intuition is for them and how they incorporate this form of knowing into the complexity of their midwifery practice. The study found that the experience and utilisation of the independent midwives' intuition is a complex phenomenon that included the reception of subtle cues, own emotions, bodily-felt sensations, images and dreams. Such ways of knowing provided practice-relevant knowledge that can be either specific or non-specific and can serve various levels and kinds of use (for example, from directly increasing generalised alertness to specific directions for treatment). The findings result in a novel typology of the essence of midwifery intuition and the different nuanced ways it comes to be utilised, developed, and confirmed or disconfirmed within the holistic trajectory of practice. The study concludes with a consideration of how the findings contribute to existing scholarship

in the area as well as the implications for practice and education. This comprises how the identification of the salient elements of the midwives' intuition has contributed to the understanding of the phenomenon and may aid other midwives and students in developing and enhancing their own intuition. This will provide assistance in enabling intuition to be recognised as a first person rational form of authoritative knowledge to be utilised, and at times, prioritised alongside other forms of practice knowledge. Recognising intuition as part of a holistic knowing will enhance individualised, safe, maternity care for women and autonomous, transparent decision making for midwives. It is recommended that the provision of reflective workshops and reflection during revalidation will enable clarification of the phenomenon and enable other practitioners to develop this form of artistry. It is also recommended that models of care that promote this intimate way of knowing are utilised in maternity provision.

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Chapter 1 Introduction and background to the study

A number of researchers, social scientists, educationalists and midwifery leaders have asserted that intuition is a potentially useful form of knowledge (Davis-Floyd and Sargent 1997; Wickham 1999; Brown 2006; Ólafsdóttir 2009; Scammell and Stewart 2014). They propose that it can advance midwifery practice as it forms part of the complexity of women's experiences and midwifery practice. It has been advocated that intuition in midwifery can shape clinical judgment and consequently facilitate safe, individualised care (Dixon 2010; Barnfather 2013). Intuition has been hailed by nursing theorists as a perceptual knowledge that is derived from experience and expertise (Benner 1984; Gobbi 2005). There is however, a dearth of research exploring the nature and use of intuition in midwifery in the United Kingdom (UK). It is proposed that this study will address this gap in knowledge and provide a means of exploring intuition within midwifery practice. It is anticipated that the findings of this study will suggest ways in which intuition can be utilised as an authoritative source of knowledge. It is not however the intention of this study to assert that intuition can be seen to exist alone. It is suggested that its use is juxtaposed with cultural understandings, personal experiences, education, training and applicable scientific findings (Polkinghorne 2004).

To provide background to the study, this introduction will examine the context of intuition within the dominant scientific paradigm. It will also examine the current paradigm of midwifery knowledge and analyse its political context within the maternity care system in the UK. The importance and relevance of intuition as a form of midwifery knowledge will then briefly be presented. This study is utilising descriptive phenomenology as a research methodology. The justification for this

choice is presented within the methodology and methods chapter (see chapter three, p.64). To introduce this methodological stance the chapter will conclude with a consideration of how the phenomenological question is important to the subject being researched and provide an introduction to the intended cohort group for data gathering. It will also provide a research focus for the review of the literature. Throughout this dissertation elements will be written in the first person to denote responsibility and authority of the author in providing a narrative involving the self (Webb 1992). The next section analyses the current context of intuition as a form of knowledge within the scientific paradigm.

1.1 The context of intuition within the dominant scientific paradigm

Out of the diversity of ways of knowing in health care has emerged a hegemonic emphasis on knowledge that is externally obtained and based on scientific principles (Davis-Floyd and Davis 1997). This has been a legacy from the scientific revolution that occurred during the age of the enlightenment led by Descartes and his philosophical heirs (Rodis-Lewis 1999). These protagonists have underpinned the philosophy of modern science (Rodis-Lewis 1999). Scientific knowledge has subsequently broadly been conceptualised as:

“the use of deductive reasoning to uncover patterns and consistencies among controlled observations”

(Polkinghorne 2004, p. 19).

As a result of this philosophical underpinning, modern scientific knowledge-seeking is portrayed customarily as value-neutral, objective, rational and dispassionate (Harding 1997; Nakielski 2005). Conversely, intuition has been defined as:

“The act or faculty of knowing or sensing without the use of rational processes”

(Davis-Floyd and Davis 1997, p.148)

and:

“The ability to understand something instinctively, without the need for conscious reasoning”

(Oxford English Dictionary 2012).

This seemingly conceived lack of rationality within intuition can be seen to militate against the ideals of the socially constructed parameters of science (Harding 1997) and intuition has consequently been derided by scientists (Wickham 2004).

It appears that intuition is similarly marginalised within the UK’s health system. The current culture of modern health care is based upon evidence based practice which has been defined as:

“the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients”

(Sackett et al. 1996, p.71).

Intuition is not viewed as a rational or evidential form of knowledge by the medical profession who are consequentially seeking to remove its use from decision making in evidence-based practice (Olatunbosun et al. 1998; Scammell and Stewart 2014). This is due to a drive for practice purely based on research based evidence (Olatunbosun et al. 1998; Scammell and Stewart 2014). The relegation of intuition is similarly reflected within midwifery practice in the UK. This is not to say that it is not being utilised as a form of knowledge by midwives, its use, however, has been diminished to a clandestine and subversive practice (Jowitt 2007; Scammell and

Stewart 2014). To provide further context to the study, the current status of intuition in midwifery practice and its historical perspective will now be analysed.

1.2 The current paradigm of contemporary midwifery practice

Midwifery practice established its autonomy as a profession in 1948 with the inception of the National Health Service (NHS) (Borsay and Hunter 2012). The knowledge that predominately underpinned midwifery practice was, at this time, experiential and intuitive (Bryar and Sinclair 2011). In the 1980s, however, this diverged to the “collective control” of practice governed by guidelines and policies (Kirkham 1989; Scammell and Stewart 2014, p.84). This change resulted from the directives of successive governments who deemed practitioners’ autonomy as problematic (Kirkham 1989). This was due to the increasing cost and identification of risk factors which were illuminated by inquiries into cases of avoidable morbidity and mortality (Scammell and Stewart 2014). As a result of costs to the NHS incurred by escalating litigation from these inquiries, the ‘New Labour’ government in 1997 launched an initiative to reduce risk and standardise care. This was entitled: ‘clinical governance’ (Department of Health (DH) 1997). This initiative subsequently resulted in a health system dominated by evidence based practice and created a systematic and uniform approach to clinical practice (Scammell and Stewart 2014).

Maternity guidelines have been largely developed by the government funded National Institute for Health and Care Excellence (NICE). NICE guidelines are underpinned by hierarchies of research evidence, with the pinnacle being meta-analyses of quantitative research trials and systematic reviews (Downe and McCourt 2008). There have, however been critics of prioritising the quantitative

research paradigm for health care where randomised controlled trials (RCTs) are considered the gold standard (Downe and McCourt 2008; Walsh 2011). It is argued that this reductionist approach, which ascribes to the principles of the certainty of cause and effect, does not allow for all the nuances within individual experiences and the complexities of health care (Downe and McCourt 2008; Walsh 2011).

NICE guidelines demand that care during childbirth should come under “the oversight of clinical government structures” (NICE 2007, p.33). This has resulted in a scientific-bureaucratic approach to care. This state of affairs has been exacerbated because guidelines have become a measurement for quality assessment for health care providers (Walsh 2011) and central to a Trust’s indemnity insurance funding level by the Clinical Negligence Scheme for Trusts (CNST 2012). It is of note that the CNST has now been replaced by the NHS Litigation authority (NHSLA). This does however operate with the same terms of reference as the CNST (NHSLA 2013). Within maternity care the evidence for some practices however, is lacking. The evidence base for performing vaginal examination for example, is limited and even in certain circumstances associated with risk:

“There is low quality evidence on the frequency of vaginal examinations during labour, with some evidence that the number of digital vaginal examinations is associated with neonatal and maternal sepsis, where the membranes rupture prior to the onset of labour”

(NICE 2014, p.526).

The practice is, however, subject to intrapartum guidelines which recommend regular examinations and interventions if set parameters are not achieved (NICE 2014). Consequentially, the procedure has become subject to debates concerning the ethics of consent rather than the potential benefits or risks of the procedure

(Stewart 2004). This lack of evidence provides scant information for women to make decisions and militates against the professional directive of informed choice (Nursing Midwifery Council (NMC) 2015, p. 5) which states:

“make sure that any information or advice given is evidence- based” .

This creates a dichotomy and dissonance for midwives (Hunter 2005). Where such inconsistencies appear, Scammell and Stewart (2014, p.94) found that midwives would utilise “covert and subversive ways of knowing and doing”, including intuition, to avoid the woman being subjected to a vaginal examination or they would fail to record the results of examinations that did not meet the set criteria of progress in labour, in an effort to reduce intervention into the woman’s labour. This subsequently resulted in reducing the risk of intervention and its concomitant morbidity for the woman and her baby; however the midwives were unable to articulate or record this positive practice knowledge. Scammell and Stewart (2014, p.84) concluded that the midwives, through their actions: “creatively subvert the scientific-bureaucratic approach to care”. Jowitt (2007, p.2) concurs with Scammell and Stewart’s (2014) notion of utilising subterfuge, asserting that both:

“Midwives and women have to resort to subterfuge to get round the system”.

This sentiment has been echoed by earlier research studies into midwifery practice (Kirkham 1999; Hunter 2004). Kirkham (1999, p.734) termed this form of subterfuge as: “doing good by stealth”. It is, however, suggested that this covert activity whilst supporting the success of the scientific-bureaucratic approach to care through its risk reduction does nothing to support midwifery knowledge, as it is not recorded or recognised. Without evidence of its beneficial use it remains an unrecognised form of knowledge. Protagonists have consequently advocated the importance of articulating when intuition is utilised to inform practice, so its value may be acknowledged (Siddique 2005; Steinhauer 2015).

There appears to be a contradiction in the government directives which on the one hand have mandated clinical governance (DH 1997) and on the other have recommended individualised woman's choice and control in their maternity care (DH 1993). Since the publication of "the Changing Childbirth report" (DH 1993) successive government documents, together with professional directives from the Nursing and Midwifery Council (NMC) have advocated a holistic, woman- (or patient-) centred approach to care (DH 2004; DH 2005; DH 2010a; NMC 2015) that prioritises choice. Whilst there is a rhetoric of choice, it is very difficult for women and midwives to go against the: "dictates of the standing operating procedure of the maternity system" Jowitt (2007, p. 2).

Clinical governance recommends a limited choice with its focus on risk prevention rather than individualised care, and could be considered to dehumanise care. Sackett et al.'s (1996) original seminal paper, concerning evidence based practice, however, emphasised the use of not only evidence but also practitioners' experience and expertise as well as the 'patient's' choices. Walsh (2011, p.7) concurs with this assertion and echoes Sackett et al's. (1996) sentiment advocating that:

"Any discussion of evidence needs to engage with women's priorities".

Unlike evidence based practice, intuition and other more holistic forms of knowing are centrally focused on the woman or individual receiving care (Ólafsdóttir 2009) and their use, alongside evidence based practice, may serve to ameliorate this dilemma. The importance of intuition as an authoritative form of midwifery knowledge and its role in improving and humanising care for women will be analysed in the next section.

This discussion has demonstrated how intuition has become marginalised within health care and midwifery due to the hegemony of evidenced based practice and has briefly discussed how midwives utilise intuition to reduce risk, albeit in a covert way. It is asserted, however, that this phenomenon will remain tacit through both its covert use, and its lack of definition. The next section of this introduction, providing further background to the study will briefly present how intuition can be a potentially useful form of knowledge to improve care for women and provide a rationale for this study.

1.3 The importance and relevance of intuition as a form of midwifery knowledge

Intuition as a form of knowing has been associated with a connection with women (Ólafsdóttir 2009) and has been considered as part of the 'art of midwifery'. Midwifery artistry has been defined as the:

“intuitive and tacit knowledge which is used by reflective practitioners to provide high quality care”

(Power 2015, p.654).

In the previous section it was discussed how as a result of clinical governance, midwifery practice has become governed by evidenced based guidelines (Scammell and Stewart 2014) and fails to acknowledge midwifery artistry or more holistic forms of knowing (Walsh 2007). Despite this rejection of intuition by the evidence based paradigm and contemporary midwifery practice, many midwives and researchers in related fields assert that intuition is a potentially useful form of knowledge. They maintain that it offers perceptual cues in a practice situation which can be used to inform and advance practice (Bourdieu 1977; Benner 1984; Davis-Floyd and

Sargent 1997; Wickham 1999; Eraut 2000; Cutcheon and Pincombe 2001; Polkinghorne 2004). It has also been cited as an essential skill for students to learn to aid competence and confidence in practice situations (Brown 2006; Power 2015).

Intuition as part of the art of midwifery is associated with a more individualised and humanistic form of midwifery care (Power 2015). With a national agenda for humanising care in the NHS (DH 2004; DH 2005; DH 2010a) intuition, as part of holistic midwifery practice, can be seen to contribute to and support humanistic care (Walsh 2011). It has been argued that care is not as sensitive or individualised without intuition, however the dominant biomedical paradigm whilst accepting its use in a covert way do not formally recognise or value its use. The lack of value placed upon intuition is in part because it is not explicit. Without clarity of the essence of intuition, teaching and education of this form of knowledge for students and novice midwives proves problematic. A more detailed analysis of the utilisation of intuition in practice will be included within the literature review (see chapter 2, section 2.4, p. 41).

There is, however, scant research on the knowledge that derives from the art of midwifery such as intuition (Davis-Floyd and Davis 1997; Power 2015) and no studies could be found in the UK. It is acknowledged however, that one has been undertaken in the United States of America (USA) (Davis Floyd and Davis 1997) and one in Iceland (Ólafsdóttir 2006). There are also a number within nursing (Benner 1984; Gobbi 2005). It is further acknowledged that there are other strands of practice knowledge and theoretical perspectives on midwifery and nursing epistemology that must also be recognised to provide a comprehensive review of the literature within this area (Carper 1978; Johns 1995; Hunter 2008).

Prior to the introduction of the phenomenon under study, it must be emphasised that it is not suggested that midwifery practice should be dominated by intuition, and evidenced based practice marginalised. It is acknowledged that evidence based practice has done much to improve the quality and safety of maternity care. It is asserted, however that a singular epistemological approach is too inflexible and one dimensional. This sentiment is expressed by Enkin et al. (2006, p. 268) leading obstetric researchers in the drive to underpin practice with evidence:

“Naive efforts to simplify the management of pregnancy and childbirth through standardized formulas, evidence- based protocols, are failing, and we are beginning to recognize anew the complexity of pregnancy and birth as life events to be experienced rather than managed”.

There could be a more flexible and less dogmatic approach to midwifery knowledge and maternity care where there is a continuum of practice which embraces both scientific evidence and midwifery artistry such as intuition (Fry 2007; Walsh 2011; Power 2015). This advocates a synthesis of ways of knowing individualised to the woman and the context of her care. Without, however, a clear understanding of intuition this form of knowing is difficult to recognise and disseminate.

It is evident that the existing research still lacks a descriptive foundation (Benner 1984; Brown 2006). This is in part due to the ‘tacit’ nature of intuition in terms of how the research and literature lack clarification of its salient elements. The utilisation of the phenomenological research methodology, and specifically the phenomenological question, however addresses this dilemma. The phenomenological research method does not just provide a conceptual clarification or a philosophical definition of intuition; nor does it provide findings that define intuition in various ways. What the phenomenological research method does do is provide a foundation of what intuition is, evidenced by individuals’ experiences

(Giorgi 2009). It is now important to further consider the nature of the phenomenological question as this encapsulates the distinctiveness of this study. To explore this concept, it is necessary to return to the founder of phenomenology: Edmund Husserl, and his notion of 'quiddity' or the 'whatness' of phenomenon which introduces the next section:

1.4 The nature of the phenomenological question

This section will explore the nature of the phenomenological question and its relation to the phenomenon under investigation. To provide the necessary philosophical underpinnings of the study, it is imperative to briefly introduce the philosophy of phenomenology and its principal founder Edmund Husserl (1859-1938). Husserl introduced his concept of phenomenology in his seminal book 'Logical Investigations' in 1900. (Husserl 1900; Dahlberg et al. 2008). Husserl was originally a mathematician, and in the first part of 'Logical Investigations', he sought to comprehend the relationship between figures and numbers and what they represented. During this exploration he became disillusioned with the abstract quantitative nature of mathematics and questioned what it was related to (Husserl 1900; Dahlberg et al. 2008). He asserted that the whatness of a phenomenon was the most important thing to consider and this by its nature involved a qualitative dimension (Dahlberg et al. 2008). These qualities could only be elucidated by obtaining descriptions of the 'lifeworld'. This he later defined as the world as immediately or directly experienced in the subjectivity of everyday life (Husserl 1931). Husserl described the lifeworld as seamless and relational where everything is interconnected. He asserted to reach the essence of a phenomenon it was necessary to describe, and not measure or explain, its qualities as they were experienced in the lifeworld. This illuminates how the phenomenological question is

concerned with the 'whatness' or what has been termed the 'quiddity' of a phenomenon. Quiddity can be defined as the inherent nature or the essence of something, or more simply the qualities that makes a thing what it is (Oxford English Dictionary 2012). From this understanding, the phenomenological researcher must focus on how the phenomenon appears descriptively and qualitatively. It is also necessary to obtain descriptions from where they are most deeply experienced. This underpins Merleau Ponty's (1945) assertion that the experience of living is greater than what is cognitively known. Giorgi (1997, p. 238) similarly conceptualises how a description of the lived experience can illuminate a phenomenon by the distinctiveness it provides:

“Phenomenology has had an impact on 20th-century thinking not only because of its rigorous descriptive approach but also because it offers a method for accessing the difficult phenomena of human experience”

Giorgi (2009, p. 118) asserts how the phenomenological method can provide descriptive adequacy of the phenomenon:

“the criterion is one of adequacy, defined as a description that is sufficiently articulate so that new, insightful knowledge about the phenomenon being studied can be obtained”

Husserl (1931) further affirmed that the whatness must be grounded phenomenologically by the existing boundaries within the lifeworld. This was based on his concept that a phenomenon has an essence and variations. These concepts will however be further explored in chapter 3, (p. 64) where the methodology of the study is presented.

As the phenomenon under study: *midwifery intuition* lacks clarity and definition, the phenomenological question and methodology provide the most fitting means to explore the topic. To fulfil the qualities of a phenomenological study the research

question must explore the whatness, or invariant essence of what midwifery intuition is. This can provide a template or a foundation for the concept and how it is experienced in the lifeworlds of midwives explicitly. For a phenomenological study to be rigorous and effective it is vital to obtain descriptions of the phenomenon from where they are most deeply experienced. This introduces the next section which identifies a cohort of midwives who are able to utilise multiple forms of knowledge, including intuition, to inform and underpin their practice and provide descriptive adequacy of the phenomenon (Ashworth 2000).

1.5 Utilising a cohort where the phenomenon is experienced

It has been discussed how the dominant paradigm within health care places a hegemonic emphasis on scientific principles and reducing risk through clinical governance. This has resulted in current midwifery practice being dominated by evidence based guidelines and policies (Downe and McCourt 2008; Walsh 2011). There was at the time of the study, however, one area of midwifery whose practice was not dominated by hospital guidelines: independent midwifery. Whilst this model of midwifery has to follow the guidance of a professional regulatory body (NMC 2012) independent midwives have the freedom to practice outside hospital policies as independent midwives are contracted privately by women and their families. It has been attested that this has enabled them to develop areas of midwifery knowledge and practice without constraint of the bio-medical model (Davis 1995; Gaskin 1996; Davis-Floyd and Davis 1997). The bio-medical model is a conceptual model of care that excludes psychological and social factors and includes only biologic factors in an attempt to understand a person's condition (Oxford Medical Dictionary 2015). In obstetrics it has also been coined 'the medical model' or 'the technocratic model' and constructs pregnancy as a disease and potentially risky and

pathological (Davis–Floyd and Davis 1997). To manage risk the bio-medical model deems it necessary to frequently monitor, test and intervene in the childbirth continuum (Worman-Ross and Mix 2013).

Independent midwifery however does not fall into the constraints of the biomedical model as it has adopted a social model of care. This social model of care acknowledges the complex milieu of maternity care (Enkin et al. 2006). It must be however, acknowledged that whilst NHS midwives endeavour to provide a social model of care, endorsed by government policy, they are frequently thwarted by the constraints of the system (Hunter 2004; Mackenzie Briers and van Teijlingen 2010).

Independent midwifery however, contracts outside of the NHS enabling midwifery practice that has more freedom and autonomy. The independent midwives' freedom and autonomy to utilise multiple sources of knowledge has provided a rationale for utilising a cohort of independent midwives to investigate the phenomenon under study. Further information regarding this cohort will be included within the literature review in the next chapter (section 2.8, p.58). The focus for the literature review will now be considered.

1.6 Providing a focus for the literature review

As there is a dearth of research exploring the nature and use of intuition in midwifery in the UK; it is proposed that this study will provide a means of exploring the existing context of intuitive knowledge within a cohort of independent midwives and suggest ways in which it can be utilised as an authoritative source of knowledge. Given the complexity of defining the concept of intuition, and the dearth of research and literature concerning midwifery intuition it is proposed that the focus

for the literature review must investigate in as much detail as possible the extent and meaning of the phenomenon within different disciplines. One of the aims of a literature review within a phenomenological study is to provide a phenomenological question that will offer an understanding into the nature or whatness of the phenomenon 'intuition'. The whatness should include what are the boundaries of intuition, its commonalities and differences with other forms of midwifery knowledge and how it exists in practice situations. Further explanation of how this will be undertaken will be included in the next chapter, the literature review (section 2.9, page 61). This first chapter will now be concluded.

This introductory chapter has explained the focus of this study, acknowledged the complexity of this area and considered the context of this knowledge within the dominant scientific and health care paradigms. It has also briefly introduced the concept of intuition and the benefits of utilising it as part of midwifery practice. This first chapter has also presented the relevance of the phenomenological question to the topic under investigation and the importance of selecting a suitable cohort that will identify a richness and depth of description of the phenomena. With this in mind, the focus for the literature review has been presented. The following chapter will explore and critique the research and literature concerning the nature and use of intuition in midwifery and allied health professions, justify why the study is required and provide the phenomenological research question for the investigation.

Chapter 2 Literature review

Chapter two will present the search strategy utilised to provide a comprehensive conceptual literature review of intuition. It also serves to acknowledge and make explicit my interest and agenda in keeping with the methodology used (see section, 2.1.1, p.28 and section 2.7, p.55). To defend this conceptual choice it must be noted that this is not to say a review of relevant empirical studies was omitted. This was undertaken, however, with a paucity of studies evident in midwifery a conceptual review was considered more rigorous for the phenomenon under study.

To provide clarity and transparency for the reader a section will be included to explain the format of a phenomenological literature review. This explanation will also serve to underpin the literature review with the descriptive phenomenological philosophy of the methodology.

This chapter identifies and explores four main themes within the literature: firstly, intuition and psychology; secondly, intuition based on patterning, tacit knowledge, habitus, reflection and reflexivity; thirdly, intuition based on connective ways of knowing and embodied knowing; and finally, intuition in the context of clinical decision making and practice based judgment.

This literature review will serve to identify any gaps in knowledge which will provide the justification for the study including how it may benefit individualised care for women, midwifery practice, education, and the scholarship surrounding intuition.

The rationale for utilising independent midwives as a research purposive sample cohort group has already been introduced in the first chapter (section 1.5, p. 24) however; further justification and evidence for this choice will be included within the context of the literature review.

This chapter will conclude with the identification of the research phenomenon, present the phenomenological question, and aims and objectives for the study. The first section will now provide information concerning the presentation of a descriptive phenomenological literature review. This will commence with the phenomenological research process of “delineation of the phenomenon” (Todres and Holloway (2004, p 84). The utilisation of this process will be traced to its philosophical underpinnings to provide rigour for the study.

2.1 Undertaking a descriptive phenomenological literature review

This section will present the two phases of the phenomenological literature review. It will commence with a delineation of the phenomenon, and then consider an appropriate method for undertaking a phenomenological literature review.

2.1.1 Delineation or articulation of the phenomenon

Wertz (2005 p.170) emphasised the importance of delineating the phenomenon in a phenomenological research study and explains this element of the research process as: “locating and delineating” the presence of phenomena in the lifeworld. Todres and Holloway (2004, p 84) who give more detail to this this stage however term the

process as “articulating an experiential phenomenon for interest”. They explicate that during this stage the researcher should: “acknowledge and make explicit their initial interest and agenda” (Todres and Holloway 2004, p 84.). This notion is underpinned with the philosophical assertions of Husserl (1931) who stated that the beginning of our understanding is informed by our human “embeddedness and participation in experiential life” (Todres and Holloway 2004, p.83).

The starting point of this process for the phenomenological researcher is to find a phenomenon of interest that focuses on the meaning of lived experience (Todres 2005). Out of ethical concerns the author must find a phenomenon that is both “relevant and interesting” (Todres and Holloway 2004, p.83). The topic for delineation in this study is: *midwifery intuition*. This subject was considered relevant and interesting as intuition has been hailed in its role in advancing contemporary midwifery practice and education (Davis-Floyd and Sargent 1997; Wickham 1999; Brown 2006; Scammell and Stewart 2014). There is however a dearth of midwifery literature and studies in this area.

A literature review in a phenomenological study specifically serves to:

“locate the topic and the subject matter in a general way that can connect to everyday human concerns and directions”

(Todres and Holloway 2004, p. 84).

My “human concerns” and “directions” include both professional and personal interests. Within this study, the phenomenon *midwifery intuition* has arisen out of a multitude of contextual factors including personal experience of the phenomena from the vantage point as a practicing midwife, and a converging interest in women’s ways of learning and practice knowledge as an educationalist. My

professional stand point in terms of theoretical interests will however be discussed in depth and presented in the personal reflection of the literature review (see section 2.7, p.55). Whilst the phenomenologically inclined researcher has to be mindful and make explicit personal interests and agendas, a more “disciplined” transparency of theoretical interests is also necessary to delineate the phenomenon before formulation of the research question (Todres 2005). This research process should critically identify the limits of a phenomenon (Wertz 2005). Wertz (2005, p. 170) asserts how the delineation of the phenomenon aims to discover:

“some gap between knowledge and reality that requires qualitative knowledge, that is, an understanding of what occurs. Research is then designed to solve the problem, fill in the gap, and overcome the flaw”.

One of the aims of a literature review within a qualitative study is to inform the researcher on the current state of knowledge, theories and unanswered questions or gaps in knowledge of the phenomenon (Aveyard 2010). For the phenomenological researcher, this enables a critical theoretical delineation of the phenomenon (Wertz 2005). The focus for the literature review was midwifery intuition, a dearth of research was however found in this area. A number of studies and wealth of literature was discovered however within the disciplines of nursing and psychology.

From the previous discussion, it is clear that the purpose of the literature review in a phenomenological study is to elucidate not only the theoretical boundaries of the phenomenon under study but also the researcher’s interests and agenda in this analysis. The aims of a phenomenological literature review would not therefore be served by a systematic review which is governed by a prescribed methodology, or a

traditional approach which adopts a critical method and aims at assessing theories or hypotheses (Jesson et al. 2011). Whilst the method of both these reviews essentially critiques the methods and results of research studies (Jesson et al. 2011) they do not serve to locate the context of the phenomenon or ensure that it is connected to “everyday human concerns and directions” (Todres and Holloway 2004, p.84).

The conceptual review however, aims to blend areas of conceptual knowledge which aids comprehension of the phenomenon being explored (Jesson et al. 2011). This method has at its core a purpose to:

“compare and contrast the different ways in which authors have used a specific word or concept”

(Jesson et al. 2011, p 79).

This choice of review provides a method to examine the state of knowledge of a phenomenon but also vitally ensures that the phenomenological researcher is fully aware of the shared meaning and understanding of the words used within their topic of research. This would suggest a conceptual review to be the most appropriate method for a descriptive phenomenological literature review. In addition, the conceptual review is useful when reviewing subjects that are often discussed in a confused way (Jesson et al. 2011). This type of review consequently provides an ideal method for reviewing the phenomenon under study, intuition, which is not easily comprehensible (Ólafsdóttir 2009).

The process of the delineation of the phenomenon and the rationale for the choice of a conceptual literature review for a descriptive phenomenological study has been

described. This has been undertaken with an aim to provide transparency for the reader. The search strategy for the conceptual review will now be presented.

2.2 Search Strategy

The definition of the phenomenon under study *intuition* is fraught with difficulties (Ólafsdóttir 2009) and by attempting to do so there is a danger of restricting its full and complex meaning, particularly in terms of how it may relate to midwifery practice. It is also significant that different disciplines have different understandings and use of core concepts, such as intuition (Mackay 2007). For this reason, and to fulfill the criteria of the conceptual review, a number of searches were completed and are presented below. It is of note that the body of the scholarship concerning intuition in nursing and midwifery was carried out within the 1980s and 1990s, so the search criteria and literature analysed reflects this finding. One paper is also included from 1978 as the work is considered seminal. Similarly, it was also necessary to research early seminal psychological theories of the unconscious mind and intuition which date back to the 1920s.

A search of the midwifery and allied health literature using Academic Search Premier, British Nursing Index, CINAHL, MEDLINE, MIDIRS and Proquest databases was initially undertaken utilising the word intuition. In addition a search was undertaken of the Proquest and ETHOS index to thesis. Electronic searches were undertaken from the commencement of the databases to the present (1983-2016) using the following key words (as a keyword, title or abstract):

Intuiti* and midwifery

Intuiti* and midwifery knowledge

This initial search illuminated that intuition was frequently associated with nursing theory and knowledge and the term decision making. So a further search was undertaken using the following key words:

Intuiti* and nursing

Intuiti* and nursing knowledge

Intuiti* and midwifery decision making

Intuit* and nursing decision making

This search generated further terminology of the following: inner knowing and knowledge, tacit knowledge, habitus, know how, reflection in action, reflexivity and practice, connective ways of knowing, embodied knowledge, decision making and practice based judgment. Another search of the data bases was then undertaken utilising these words. This further identified intuition based on psychological studies, so a further search was undertaken of the psychology databases including: PsycARTICLES and PsychINFO using the following key words:

Intuit*

Intuit* and decision making.

This search further revealed the term adaptive intelligent unconsciousness and heuristics. Where relevant studies were identified bibliographic references were also researched.

This review of the literature highlighted that intuition has been researched and conceptualised in psychology, clinical nursing and allied health practice; however there was a paucity of studies researching the utilisation of intuition in midwifery. Only two studies were found: one in the USA (Davis-Floyd and Davis 1997), and one in Iceland (Ólafsdóttir 2009). Whilst Davis-Floyd's study investigated midwifery intuition specifically, Ólafsdóttir (2009) focused on midwifery narratives of birthing

experiences, however this illuminated different ways of midwifery knowing; and so it will still be included within the review. The lack of studies and theoretical papers in midwifery is reflective of how meagerly midwifery epistemology has been conceptualised (Bryar and Sinclair 2011) providing further justification for the study.

A further search was undertaken prior to the submission of the thesis which illuminated no further studies of midwifery intuition within the UK. The critique of the literature cemented the review of intuition into two main relevant areas: intuition and psychology and intuition within health care. Psychological studies have been divided into Freud and Jung's original work on the unconscious mind and intuition; and more contemporary conceptions of intuition as a process of the unconscious intelligence, adaptive cognition, adaptive unconscious, heuristics and parallel processing. Intuition and health care has illuminated three main themes: intuition based on patterning, tacit knowledge and habitus, reflection and reflexivity. Secondly, intuition based on connective ways of knowing and embodied knowledge and thirdly, intuition in the context of decision making and practice based judgment. The first area derived from the literature concerning psychology and intuition will now be analysed.

2.3 Theme 1 Intuition and psychology

This section will commence with Sigmund Freud's (1925) and his scholar Carl Jung's (1954) seminal works on the unconscious mind and intuition. The conceptual review will then consider more contemporary psychological definitions. These definitions create a parallel in that they mostly all consider intuition is a product of, or arises from, the unconscious mind rather than the conscious mind, or perceived

via the senses. They do not however all clarify or concur on how exactly this happens.

2.3.1 Early psychological definitions of the unconscious and intuition

As many psychological theories connect intuition with the unconscious mind (Bargh and Morsella 2008), it is first necessary to consider this area of early psychological scholarship. Freud's (1915) seminal work, 'The Unconscious' concerning how the mind can repress traumatic memories, divided the mind into the conscious mind and the unconscious mind. Freud's (1923) subsequent publication 'The Ego and the Id' further divided the unconscious mind into the *id*, or the individual's instincts and drive and the *superego* or conscience. In this theory, the unconscious refers to the mental processes, such as instinct, of which individuals are themselves unaware. Freud (1925) however developed this model from individual case studies involving abnormal behaviour, and specifics of his model have not subsequently been supported by empirical testing (Bargh and Morsella 2008).

Carl Jung (1954) further developed Freud's earlier work and identified the concept of intuition. Jung (1954, p. 165) originally defined intuition as an unconscious process of perception or "the eyes of the background" through which "a sudden idea or hunch" erupts into consciousness. He later described intuition as the "ability to see beyond the empirical evidence" (Jung 1971a, p. 458). According to Jung, intuition was "an irrational act of perception", "not contrary to reason but beyond reason" (1971a, p. 454). Jung has asserted that intuition was a form of perception but claimed that this occurred via the unconscious, as opposed to being perceived by the senses (Jung 1971a). This presents intuition as totally separate from

empirical evidence or logic; however, Jung appears to associate it as a first person form of rationality through his words “not contrary to but *beyond* reason”. Jung defines intuition as a tacit form of knowing evidenced by Jung’s use of the terms “background” and “unconscious”. Jung (1971b) believed that people could be characterised by their preference of one of the two methods of perception: sensing or intuition.

Jung (1971b) defined sensing as the information that was gained externally and intuition as information that was perceived internally through mainly unconscious process. Jung’s work could be considered reductionist however, as he based his theory on four psychological personality types. Careful consideration when considering the phenomenon *midwifery intuition* must be taken with his definition of intuition as occurring via the unconsciousness as it must be remembered that Jung as a psychologist theorised and worked with different psychological states of consciousness. This is opposed to midwifery care and artistry that may be also based on utilising the senses in terms of observing and monitoring women (Ólafsdóttir 2009). It is however, acknowledged that Jung recognised both sensing and intuition albeit as separate personality types.

More recently in psychology, intuition has been conceptualised as: *unconscious intelligence, adaptive cognition, adaptive unconsciousness, heuristics* and *parallel processing*. The theory of an unconscious mind that could be *adapted* was influenced by both Freud and Jung’s views on the unconscious mind. Freud’s (1925) psychological studies asserted that much of the mental content stored in the unconscious mind was necessarily repressed. The adaptive unconscious theory emphasises however, that the unconscious stores information that can be beneficial to the individual (Bargh and Morsella 2008). This concurs more closely with Jung’s

(1971a) theory as conceptualising the utilisation of information derived from the adaptive unconscious as a first person form of rationality. These more contemporary psychological definitions of intuition will now be considered. These more contemporary terms however, are used interchangeably in the literature so will be considered together.

2.3.2 Intuition as an adaptive, unconscious, intelligent process

Bargh and Morsella (2008) critique the different emphases on the unconscious mind from the perspectives of cognitive and social psychology. This is of relevance when comparisons are made to Freud and Jung who were both psychodynamic theorists and therefore adopted a different philosophical underpinning. The psychodynamic approach includes all the theories in psychology that see human functioning based upon the interplay of 'drives' or internal psychic energy within the person, especially those within the unconscious, and between the different typologies of the personality (Sapp 2010). In cognitive psychology, however the unconscious mind is considered limited to subliminal information processing. As the stimuli for subliminal stimuli are moderately weak, cognitive psychology studies have consequently concluded that the unconscious is "dumb" (Bargh and Morsella 2008; p. 73). This judgment however can be challenged. In Freud's (1915) earlier work, the use of the term unconscious was originally based on behaviour that was not intentional or in an individual's conscious awareness, for example, 'Freudian slips'. The unconscious can be seen therefore to be based on:

"one's unintentional actions and not on one's ability to process subliminal-strength information"

(Bargh and Morsella 2008, p. 74).

Similarly to Freud, social psychologists have focused on mental processes, rather than stimuli. A contemporary review of relevant research has revealed that the unconscious mind is far from ignorant and is a “pervasive, powerful influence” over higher mental processes such as individual’s judgment, decisions and the reasons for behaviour (Bargh 2006; Bargh and Morsella 2008, p.75). Bargh and Morsella (2008) maintain that evolution has affected the unconscious mind; they further advocate that early learning and culture are similarly influential. Through an examination of evolutionary biology, Bargh and Morsella (2008, p.76) further assert that the unconscious mind or intuition guides actions and precedes reflection:

“We are often guided by our feelings, intuitions and gut reactions, which prioritise the things that are important to do or attend to”.

The importance of intuition as a form of unconscious intelligence is being increasingly accepted by psychological theorists (Gladwell 2005; Isenman 2013). Gladwell (2005; p.23) describes this concept as "thin-slicing" which he defined as:

“the ability of our unconscious to find patterns in situations and behaviour based on very narrow slices of experience”.

Gladwell (2005) explicates this as the individual’s ability to assess what is vital from a limited period of experience. This assessment involves mental processes that work rapidly and automatically from relatively little information. Gladwell (2005) purports that today's society resides in an age of information overload and suggests that spontaneous or intuitive decisions are just as good, if not better, than rational ones underpinned by volumes of analysis. Evidence to substantiate his claims is derived from human examples of judgments which are based on intuition rather than rational analysis of a situation. Gladwell could however be considered reductionist as he believes that most situations can be simplified to basic underlying causes or thin slices of patterns. Gladwell’s theory has also been criticised as being unsubstantiated by rigorous evidence and marginalised as popular psychology

(LeGault 2006). Alternatively, Girgenzer (2008) asserts that Gladwell's notions of thin slicing or snap decisions are the result of heuristics, or rules of thumb. Girgenzer (2008) conceptualises that intuition is the ability of the unconscious mind to discover these rules and apply them without conscious awareness. He does however advocate that these rules can also be applied consciously. Girgenzer (2008) maintains that an individual's ability for intuition, or choosing a rule and evaluating whether it is right, is dependent on the intelligence of the unconscious. Isenman (2013) similarly challenges Gladwell's work asserting that his theory of "thin slicing" is too simplistic. Whilst Isenman (2013) concurs with Gladwell's and Girgenzer's (2008) notion that pattern recognition is central to unconscious intelligence or adaptive intelligence, she asserts that the patterns recognised by the unconscious are more complex than thin slicing or simple heuristics. Isenman (2013, p.153) asserts that intuition is often where

"all the relevant information is processed very rapidly below the surface
in an interactive manner"

She asserts that on many occasions thin slicing or heuristics cannot always detect an underlying cause and contests the idea that the whole can be captured in a simplistic pattern. Isenman (2013; p.157) identifies an alternate concept of "adequate slicing" where she maintains an adequate or sufficient amount of information is needed over time to populate the brain's networks. The unconscious mind's capacity to deal with complicated patterns and multiple sources of information she has coined "intuitive processing" (Isenman 1997, p.395). This involves a process known as "neural network information processing" where neurones interact simultaneously with each other (Isenman 2013, p. 153). This in turn enables an individual having a sense of the whole and enables an expanded form of pattern formation and creation. This is attributed to the unconscious mind's

ability to examine complex situations holistically and reframe problems which Isenman (2013) believes can have startling results and the capacity for:

“sometimes dazzling pattern formation/creation below awareness that resulted in and is illuminated in certain experiences of intuition in turn greatly enhanced the potential prowess of the human mind”.

Quirin (2013) concurs with Isenman’s notion of intuition, however terms intuition as ‘parallel processing’. Quirin (2013) similarly asserts that intuition is associated with creativity as it contributes to coherent patterns of information that generate original solutions to complex situations.

Having considered the main psychological concepts of intuition, these will now be summarised and evaluated.

This conceptual analysis has considered Freud’s original definition of the unconscious as an area of the mind that can contain tacit information, albeit in a repressed capacity. Jungian theory then conceptualised intuition as part of the unconscious mind and a potentially useful source of knowledge, albeit tacit in nature. Jung can however be criticised for a kind of reductionism in that he conceptualised intuition in a binary way that was differentiated from ‘sensing’ and used this distinction to underpin personality types, thus limiting its potential use. Both Freud and Jung have recognised intuition, or in Freudian theory ‘instinct’, as a form of tacit information, however where Freud aligns this information with repression, Jung aligns it with personality typology. Intuition as an adaptive form of unconscious intelligence has been presented as a more contemporary definition of

intuition. This viewpoint conceptualises intuition as a vital part of intelligence necessary for human survival.

The psychological theories presented here attest to the complexity of intuition as an unconscious process; however they all support the usefulness of intuition especially when involved in complex judgments. It is significant to recognise that not all cognitive psychologists attest to the usefulness of intuition, asserting that if relied upon it can lead to poor judgements (Hammond 2010). The theories presented however provide the most appropriated description of what intuition is and where it is derived from for the purposes of the literature review. This is certainly key to midwifery and health care which introduces the next section concerning the scholarship centering on intuition within midwifery and allied health professions. The following conceptual review has been divided into three further main themes: intuition based on patterning, tacit knowledge, habitus, reflection and reflexivity; intuition based on connective ways of knowing, emotion and embodied knowledge; and intuition in the context of decision making and professional judgment. It is acknowledged that these are complex themes; however this demonstrates the multifaceted nature of intuition. This complexity also serves to explore the theoretical boundaries of the phenomenon, fulfilling the criteria for delineating the phenomenon in a phenomenological literature review (Wertz 2005).

2.4 Theme 2 Intuition based on aesthetic knowing, patterning, tacit knowledge, heuristics, habitus, reflection and reflexivity

This second theme carries the greatest level of complexity. Whilst the combination of so many concepts within one theme may be questionable, the justification of their

inclusion is their interrelatedness. Aesthetic knowing is a generic term for tacit knowledge, whereas habitus, patterning, and heuristics are terms aimed at explicating the concept of tacit knowing or knowledge. Reflexivity and reflection are similarly linked to tacit knowledge however whilst they are not used as a concept to explain this form of knowing they have been included within this theme as they are a suggested means of unleashing intuition for practitioners. It is acknowledged that complexity is increased however through the debates concerning whether or not it is possible for intuition or tacit knowledge to be released. These concepts and debates will now be explored in this second theme of the conceptual review. Juxtaposed to this thematic analysis will be how this theme resonates or disagrees with the first theme, intuition and psychology.

There is no consensus in the literature concerning health care in terms of the role and meaning of intuition. It has however been debated at great lengths by nursing theorists. Within any discourse on nursing knowledge, including intuition, Carper's seminal work as far back as 1978 is frequently cited (Johns 1995; Jacobs 2013). Carper recognised over thirty years ago that there was a fragmented approach to nursing epistemology and that it was biased by a scientific paradigm. To ameliorate this state of affairs she conceptualised four forms of knowing comprising: empirical (or scientific), aesthetic (or artistry), personal knowing and ethics. Carper's form of aesthetic knowing or artistry however is the most resonant with intuition. Carper (1978) defined aesthetic knowing as a process of perceiving or grasping the nature of a clinical situation.

Hunter (2008) similarly, in her hermeneutic study of midwives' from the USA ways of knowing in poetry, has conceptualised different forms of knowledge to inform midwifery practice. She asserted that the midwives from her study utilise three

forms of knowledge to inform their practice. These included: self-knowledge that was derived from personal belief systems. This is comparative to Carper's notion of personal knowing. Hunter's second form of knowledge was identified as informed or scientific knowledge, resonant with Carper's empirical knowing. The final form of knowledge conceptualised by Hunter is grounded or experiential knowledge. This could be considered comparable to Carper's aesthetic knowing. This is however only in terms of a form of knowing that realises:

“the particulars of a situation instead of universal components of the situation”

(Hunter 2008, p. 412).

Hunter (2008) is a strong advocate of intuition and asserts that it is an integral component of the knowledge paradigm within midwifery. Her study however, whilst mentioning artistry does not specifically mention intuition, or ascribe it to a form of knowing. Hunter (2008, p. 413) does however conclude that there is a need for midwifery researchers to pursue future studies that explore “intuition and experiential knowledge as legitimate forms of truth”.

Returning to Carper's (1978) seminal work on nursing knowledge, she asserted that empathy was the core skill necessary for aesthetic knowing. Johns (1995) has however subsequently challenged this viewpoint and asserts that intuition is a more fitting 'skill' to enable the process of aesthetic knowing. Johns (1995, p. 228) conceives intuition as a core skill which is “based on an understanding of the situation as perceived”. Johns (1998, p.2) concurred with Jung's conception of intuition as 'tacit knowing'. He does not however, state whether intuition is perceived via the senses or through the unconscious.

Intuition has similarly been defined as 'know how', consisting of tacit knowledge associated with a created understanding of a situation without having a rationale (Benner and Wrubel 1989, p. 6). Bourdieu (1990) concurs with this notion, however has coined the term 'habitus' to describe the tacit knowledge members of a culture or health professionals create within complex practice. Bourdieu (1990) makes some attempt to explicate why practitioners' knowledge is tacit by explaining that as practitioners develop a 'habitus' which involves taken for granted meanings, knowledge and skills it recedes to the background. This appears to concur with Jung's (1954, p. 165) notion of the "of the background", however, this remains an abstract term. Paley (1996, p. 669) however questions whether background information is always useful and asserts that this may include "deeply ingrained, taken for granted and yet inappropriate" information.

Benner et al. (2010, p. 178) and Wickham (2004) have attempted to cement the term intuition more rationally with the psychological term "patterning". Benner et al. (2010) have described patterning as recognition of a pattern which occurs when the signs and presenting symptoms of a problem are compared with patterns recognised from an individual's memory. This pattern is then matched to the presenting trend.

Wickham (2004) has defined patterning as the subconscious recognising the situation but the rational brain not recognising the same signs or pattern, which aligns with Jung's and other psychological theories of intuition as being associated with differing levels of consciousness and pattern recognition. Benner (1984, p. 2) however, coins patterning as "expert know how" based on an experiential knowledge base. She based her notions of expertise from the works of Dreyfus and Dreyfus (1986) who were working in the field of artificial intelligence and came to the

conclusion that human 'experts' process information entirely differently from computers.

In Benner's (1984) seminal phenomenological study, which researched a cohort of nurses from the USA, she concluded that intuition could be diminished if intuitive or 'expert' practitioners tried to analyse their performance (Benner 1984). This does however suggest that only 'experts' or highly experienced practitioners can experience intuition and as Paley (1996) has asserted having experience or background information does not necessarily constitute expert performance. Experiential knowledge gained may have become ingrained and be inappropriate for some episodes of clinical care. This notion of intuition and expertise has also been contested by Smith et al. (2004) who utilising psychometric testing discovered that nursing students experienced intuition in an equivalent way to experienced nurses. McCutcheon and Pincombe (2001) have similarly confirmed that intuition is not purely the domain of the expert. In their study they identified novice nurses that experienced intuition. It is acknowledged however that due to their lack of experience, the nurses were reluctant to utilise it in their practice.

Benner's (1984) study and notion of patterning and expertise, or experiential learning has however, in the main gained support by nursing theorists. Aitken (2003) more recently stated that the ability of nurses to undertake pattern recognition will develop as their knowledge base increases. Reichman and Yarandi (2002) concur but maintain that patterning is more likely to occur as nurses gain experience in a specific area of nursing. Hoffman et al. (2004) assert that with experience, pattern recognition will be replaced by more refined recognition patterns and concur that this refinement is often related to competence. Buckingham and Adams (2000) give further definition to pattern definition which subscribes to

intuition being linked to an experiential base. They describe it as a process wherein the learner links a pattern of cues to a given rule and a subsequent response. As more experience is gained, however, neural connections are created between the cues and the response and the rules are made redundant and become unconscious (Buckingham and Adams 2000). This theory connects both heuristics with pattern recognition and intuition with the unconscious which links both the psychological theories in terms of the notion of adequate slicing and parallel processing, with nursing theories. It also illuminates that intuition is perceived by the senses in terms of intuiting a pattern of cues. Buckingham and Adams (2000), however link their conception of intuition solely with experience and expertise.

Benner and Tanner (1987) further asserted that nurses 'know how' or intuition consisted of knowledge that did not follow a linear process and could not be expressed in words. Johns (1995, p. 226) has questioned this and asserted that a process of reflection could be implemented as a means of access to previous experiences in order to develop "the reservoir of tacit knowing". Herbig et al. (2001, p. 690) however, agree with Benner and colleagues and contest the view that tacit knowledge can be identified or clarified:

"As reflection is not possible for tacit knowledge ...a lack of awareness of naive or even wrong implicit theories may prevail and therefore cause errors in performance".

Rolfe (1998, p.28) and Schön (1983) have both previously challenged Herbig et al.'s (2001) notion that intuition is tacit, arguing that intuition is 'reflection-in-action' that can become a conscious act. This is termed reflexivity. Johns (1995, p.226) defines reflexivity as a process wherein the nurse:

"assimilates learning through reflection with existing personal knowledge"

This subsequently enables practitioners to respond to new clinical situations with a different perspective, or knowledge. Rolfe (1998) develops the notion of reflection-in-action as reflexive and asserts that conscious reflection-in-action entails a reflexivity which modifies the object of reflection and has a direct impact on the practice situation. Rolfe (1998) maintains that adopting this notion of reflexivity commences a repertoire of paradigm cases which can be applied through initially conscious matching and then unconscious matching. Patterning in this sense, encompasses the whole situation rather than reducing the situation to discreet parts (Rolfe 1998). Mok and Stevens (2005) agree with this concept and have discussed how reflexive knowledge can be gained through creative practice. They have formed a theory of praxis where the individual practitioner can eventually create new knowledge through a regime of patterning.

Benner et al. (1999) however have refuted this notion of reflexivity and assert that whilst a practitioner may adopt a process of thinking in action this is related to a narrative understanding, not an intellectual, reflective process. Benner et al. (1999) attest that a reflective process would compromise and deteriorate a practitioner's performance. Rolfe et al. (2001) dispute this by asserting that Benner's original study was underpinned by Dreyfus and Dreyfus' (1986) model of motor skills acquisition; health practitioners, they maintain however, mainly carry out cognitive activities and reflection-in-action could enhance performance.

Whilst it is evident that intuition is difficult to rationalise, if intuition can be a form of authoritative knowledge in midwifery (Davis-Floyd and Davis 1997) it is vital that it be rationalised or at least explored to provide further learning and knowledge transfer. Latterly, Benner et al. (2010) have changed their terminology of patterning and intuition to a sense of salience which enables the practitioner to attune to each

familiar situation. This will be further discussed in section 2.6 (p.53) concerning the concept of intuition and decision making.

This discussion of the second theme has centred on the nature of intuition and tacit knowledge, much of this analysis has been ascribed to unconscious and conscious patterning and heuristics. Utilising the senses through eliciting cues has also been discussed and the degree to which intuition can be illuminated through the process of reflection and reflexivity. Intuitive decision making based on unconscious patterning has been in the main accredited with 'expert' status (Benner 1984; Sullivan 2005), whilst this may enable competent practitioners to begin to see long term goals and wider conceptual frameworks (Sullivan 2005) this devalues students' and the (childbearing) woman's own intuition and creates a hierarchy of knowledge. By ascribing all intuition to patterning, practitioners may also be missing an opportunity to explore an area of intuition that is difficult to rationalise and thus disparaged within a deductive framework. This form of intuition comprises a type of relational knowing based on emotion and spiritual awareness which forms the next thematic analysis.

2.5 Theme 3 Intuition based on connective ways of knowing, emotion and embodied knowledge

Mok and Stevens (2005, p.30) describe intuition within midwifery practice as the notion of connectiveness; an "awareness creating relationship" or "tuning in" to the woman. Ólafsdóttir (2009, p. 192) similarly in her narrative ethnographic study of Icelandic midwives asserted that midwives would "connect" with women which enabled them to elucidate the woman's needs. Ólafsdóttir (2009, p. 201) suggested

that this development of connective knowing was often related to emotional situations that could support or restrict the midwives' knowing depending on the context. Winter (2002) in her grounded theory study of independent midwives' ways of assessing progress in labour similarly found that if a relationship broke down with a woman or her partner during labour this would restrict and disrupt the midwives' knowing. Midwives' knowing could also be disrupted if the woman was transferred from home to hospital as the midwives believed their relational intuitive knowing was not valued in the hospital settings where medical science and technology are revered (Bone 2009).

Davis-Floyd (2004) has also attributed the relationship between the woman and the midwife as a key point in intuition, asserting that the relationship between the woman and the midwife enabled the midwife to 'tune in' psychically and spiritually to subtle clues and qualitative changes during care. Davis-Floyd and Davis (1997) describe this concept in their narrative study researching a cohort of homebirth midwives from the USA and their experiences of intuition. It is acknowledged however that they do not define what is meant by 'spirituality'. The homebirth midwives interviewed described their intuition as emotional, physical, psychic and spiritual. This intuitive connection with the woman and her baby was dependent on the degree they connected to their own thoughts and feelings (Davis-Floyd and Sargent 1996).

In Davis-Floyd and Davis' (1997) study, the midwives interviewed linked intuition to their "higher selves"; however because of this spiritual connection they were unwilling to accept that intuition could be wrong (Davis-Floyd and Davis 1997, p. 159). Once again Davis-Floyd and Davis (1997 p. 159) do not define their described terms of "spiritual" and "psychic". Belenky et al. (1997, p. 54) contest the idea of

intuition or 'subjective knowledge', always being correct asserting that this leads to absolutism and can negate legitimate answers from the outside world. The participants, however, in Davis Floyd and Davis'(1997) study would justify their intuition, even if proved incorrect, mitigating that it was not intuition in the first place but use of their "rational minds" (Davis-Floyd and Davis 1997, p. 159).

Other researchers have identified the relationship between the midwife and the woman as being important to intuition and have similarly identified a spiritual or psychic relationship (Ólafsdóttir 2009; Hall and Taylor 2004). Ólafsdóttir (2009, p. 192) asserted that this spiritual relationship enabled the midwives to develop a form of "inner knowing" or "intuitive knowledge". In Ólafsdóttir's (2009) narrative study of Icelandic midwives, stories were related of sensing "something behind me". As Ólafsdóttir (2009, p.149) describes the Icelandic midwives in her study: "seemed to have contact to the spiritual world". This would include narratives that described how:

"women or transcendent people had told them who was behind them
from the other side"

(Ólafsdóttir 2009, p.149).

This notion of spirituality however enters into the arena of 'mystical' knowledge which sits firmly outside the realm of rational thinking and professional practice (Wickham 2004). Benner (1984) asserted that intuition should not be confused with mysticism, as she maintained it is only available in situations where a deep background or knowledge of the situation exists. Defining spirituality is also difficult and there may be a danger of restricting the full and composite meaning, particularly when relating it to practice situations (McSherry 2006; White 2006). Hall (2001) has

however identified features of spirituality from other health care disciplines including transcendence, searching for meaning and purpose, relational aspects and creativity and applied these to midwifery and childbirth. Intuition however is not included. There was also a dearth of research or theoretical papers across all health disciplines in the area of spirituality and intuition.

Other researchers and philosophers have asserted the importance of emotion in relation to intuition and tacit knowledge. These include nursing theorists Herbig et al., and the philosophers Polkinghorne and Gendlin, their concepts will now be discussed.

Herbig et al. (2001, p. 694) have identified that there are emotional aspects involved in tacit knowledge and have demonstrated that the information provided by tacit knowledge was important. In their nursing research they identified that nurses' tacit knowledge was more likely to be effective if they attended to their emotions. In the following excerpt the results are discussed in terms of groups of nurses that were 'successful' or 'not successful' in a simulated critical incident:

“Although both groups reported feelings as essential aspects in the situation, successful nurses seemed to be able to use these feelings as action-related information while unsuccessful nurses seemed to perceive feelings as obtrusive and irritating. “

Similarly, Polkinghorne (2004, p.110), a philosopher and psychotherapist, presents a convincing case for the use of emotion in deliberations, as it serves as sources of information for “right actions”. Polkinghorne (2004) asserts that it is frequently an emotional response to a situation rather than a detached rational thought that serves as a guide to appropriate action. Polkinghorne (2004) deliberates that

emotion can focus attention to reveal aspects of a situation that may otherwise remain hidden. This is cited as intuitive knowledge and associated with a relational connection:

“One often feels a friend’s needs intuitively before coming cognitively aware of them”

(Polkinghorne 2004, p. 110).

Polkinghorne (2004, p.130) calls for ‘embodied’ knowledge which involves the individual drawing on not only emotion but values and feelings. This is linked to the psychotherapist and philosopher, Gendlin’s (1962, p. 138) philosophy of experiencing:

“Experiencing is our interaction with life situations and the visceral meanings these situations have for us”.

Gendlin (1962) asserted that experiencing was beyond thought and conceptualised it as “bodily felt meaning” or embodied knowledge. He explicated this as an unconscious awareness that guided individual actions. Polkinghorne (2004) conceptualises embodied knowing as an implicit process and a combination of emotions, memories and the felt presence of others. He asserts that this knowing functions “below the level of conscious awareness” and is concerned with the integration of multiple values and particular needs (Polkinghorne 2004, p. 140). This notion of the unconscious concurs with the psychological theories presented, however the ‘felt’ presence of others is suggestive of utilising the senses.

This section has considered intuition as a connective form of emotional, psychic and spiritual knowing. This connection has embraced both the link between the midwife and the woman, and between the midwife and her ‘higher self’. Polkinghorne

(2004) has however further developed this concept of intuition as a form of embodied knowledge. This emphasises the importance of relationships but also acknowledges patterning and addresses the concerns of mysticism explaining the spiritual and psychic as emotions and felt presence. Polkinghorne (2004) has called for a judgment based practice to utilise embodied knowledge. This concept is now continued in the concluding part of the review which considers intuition in the context of decision making and professional judgment.

2.6 Theme 4 Intuition in the context of professional judgment and decision making

In psychology and nursing, intuition has been defined as an “effortless judgment” (Quirin 2013, p.117) based on a holistic assessment of a situation. Rew (2000) has similarly coined intuition as a decision to act on awareness:

“the deliberate application of knowledge, or understanding that is gained immediately as a whole and that is independently distinct from the usual, linear and analytical reasoning process”

(Rew 2000, p. 95).

According to Rew (2000, p. 95), intuition is a component of clinical judgment, in what is termed: “perplexing, often ambiguous and uncertain situations”. In midwifery practice, Steinhauer (2015) has associated intuition as a form of unconscious judgment. This assertion was however limited to the personal reflection of a student midwife. Jointly, however, these definitions suggest that intuition and judgment or decision making are integral. This premise is strengthened by the concept of the intuitive-humanist clinical decision making model (Banning 2007). This model is based on Dreyfus and Dreyfus’ (1986) model of intuitive judgment which comprised

a number of concepts including pattern recognition, skilled know how and a sense of salience. The emphasis of this model links intuition with professional experience and pattern recognition. Despite the word humanist however, the connection between nurse and patient are not mentioned (Banning 2007). In her study of nurses from the USA, Benner (1984) linked the process of decision making to expertise with novices utilising heuristics or hypothetico-deductive reasoning. This model of clinical reasoning is where clinical features are linked with diseases and treatments (Jefford et al. 2011). Benner (1984) asserted that expert nurses however utilised decision making based on intuition. The problems associated with expertise however, have already been explored.

Polkinghorne presents a more holistic notion of intuition as a form of practice based judgment. He defines intuitive judgment as background informed actions. Polkinghorne (2004) provides a convincing argument for a judgment based practice and suggests practitioners reflect on possible background informed actions, attend to their feelings on them and subsequently adjust their actions accordingly. This recommendation is underpinned by Polkinghorne's (2004, p.151) assertion that practice always occurs within a cultural context, in terms of both the practitioner and the "one being served" both bringing "internalized cultural understandings" and "accumulated personal experiences".

In midwifery, Jefford et al. (2011) have called for a specific midwifery decision making model to be developed which should include ways in which to make decisions in partnership with the woman. Noseworthy et al. (2013, p. 42) similarly advocate within midwifery a "relational model of decision making" where human, contextual and political factors are embedded within practice. Whilst Noseworthy and colleagues acknowledge a connection between the midwife and woman, they

do not however explicitly mention intuition. Noseworthy et al.'s (2013) and Polkinghorne's (2004) concepts appears to unify the various boundaries of intuition and decision making and embed a holistic perspective central to midwifery practice and vitally embraces the other (or in terms of midwifery: the woman) in the context of the intuition or embodied knowing. To provide the context of this embodied knowing or intuition for this conceptual literature review the next section will conclude with my personal reflections on my understanding.

2.7 Personal reflection of literature review

This section aims to acknowledge and make explicit my interest and agenda in keeping with the methodology used (see section, 3.2.1 p.82). Todres (2005, p. 108) has asserted that this is the stage wherein the researcher:

“acknowledges his or her embeddedness within a historical community of scholars”

Prior to the commencement of the literature review my agenda was to explore in depth midwives' experiences of intuition to help illuminate the essence of this phenomenon. It became necessary however, to explore other disciplines namely, psychology and nursing as there was a dearth of research and literature within midwifery. The early and more contemporary psychological conceptualisations placed intuition firmly into the realm of the unconscious mind. Whilst this explanation presented a useful theory of intuition, it did not provide examples of how intuition is experienced in the lifeworld. It also limited intuition as being perceived by the unconscious mind and not by the senses, which may be more relevant to midwifery knowing and artistry. As expected, more resonant descriptions of the phenomena

were discovered in research and literature concerning health practitioners which will now be reflectively analysed.

Benner's (1984) seminal study on nurses' experiences of intuition and her concept of patterning does appear reasonable. Her assertion however that this knowledge cannot be analysed means this knowledge remains tacit and cannot be imparted or reflected upon individually. It also appears to place the phenomenon as one dimensional and purely in the realm of recalling previously gained knowledge, albeit tacitly. It similarly distils the essence of intuition to experience and expertise which appears reductionist in terms of other theorists who have linked it to emotion and connective ways of knowing. It does however include utilising the senses through the elicitation of clinical cues which could be related to midwifery artistry. Rolfe's (1998) notion of reflexivity and reflection in action offers a remedy to unleash Benner's notion of tacit, unreachable, unconscious knowledge and illuminate it for personal learning and knowledge that can be disseminated; however it does not describe all dimensions of intuition. Opening the phenomenon into the realm of connection with others implies a relationship or 'knowing' of another and offers a further dimension to intuition. Additionally, utilising emotion and acknowledging the cultural and experiential worlds of both practitioners and those they serve broadens the phenomenon and embeds this connection. The utilisation of Polkinghorne's (2004) practitioner judgment informed by a reflective understanding embracing all these concepts provides a way to utilise and explore intuition if it is to be accessed or developed by others. This also suggests an acknowledgment of both past experiences and emotional connections and does not privilege or make absolute one form of knowledge over another. For me this addresses all of the forms of intuition explored and provides a means of unlocking or utilising this tacit knowledge.

Discovering the realm of spirituality and mysticism as intuition is not one I have personally experienced, the literature however is very sparse in this area and it is not clearly described. I have no knowledge whether the study will bring descriptions of this form of intuition, however as independent midwifery hails itself as a holistic practice embracing women's spirituality (Hayes and Flannery 2000), this is a possibility, I question how midwives as professional practitioners justify using this form of knowledge and am curious as to whether this form of intuition is used authoritatively. Finally, I wish to acknowledge my interest in Polkinghorne's (2004) convincing argument for a '*judgment based practice*' that places intuition in a continuum of knowledge. This embraces the whole individual in terms of their emotion, culture, and experience. It widens again the discourse of intuition and explores the depth of practitioner knowledge highlighting intuition as an embodied part of this knowledge. It gives an authority to intuition when used with other phenomena. Polkinghorne's conception of a judgment based practice resonated within me as a personal truth which I can personally relate to, but more importantly gives a foundation and justification for the use of intuition as an authoritative form of knowledge in practice.

The process of delineating the phenomenon has acknowledged my personal interests and preunderstandings however my intention is throughout all the phases of the research not to privilege one form of knowledge over another and to enable the phenomenon to emerge unfettered by certain personal beliefs (Giorgi 2009). This involves the process of adopting a phenomenological attitude and entering the reduction (Giorgi 2009), however, this will be defined and analysed in the following methodology chapter (section 3.2.8, p.101).

My aim for this research study is to describe and illuminate the phenomenon with the assistance of lifeworld descriptions of others' experiences. This would warrant a midwifery cohort group that have close relationships or personal knowledge of the women they care for. One facet the literature review has elicited is that intuition may be associated with a connection between the woman and the midwife. The first chapter has already illuminated how intuition is being marginalised within the NHS, but may be more apparent in independent midwifery. This model of care is underpinned by more holistic ways of knowing, alongside evidence based practice. This brought me to choosing independent midwives as a cohort group who work very closely with women developing close personal relationships over a period of time. It is appropriate at this juncture to provide evidence to support this assertion which is presented below. This will commence with a summary of independent midwifery.

2.8 Independent Midwifery- a brief synopsis

Independent midwives are practising midwives, and similarly to NHS midwives, they are registered with the Nursing and Midwifery Council (NMC) and are subject to the same statutory rules and standards (NMC 2012; 2015). Their education and qualification are the same as NHS midwives (NMC 2009), undertaking their practice-based education in NHS hospitals. Their practice is subject to statutory supervision in the same way as an NHS midwife (NMC 2012). It is acknowledged however, that this process is changing, for all midwives (NMC 2016; DH 2016). Independent midwives differ from midwives contracted through the NHS as they have chosen to work independently, contracting individually and directly to women. There has however more recently been the advent of independent group practices such as 'Neighbourhood Midwives'. Independent midwifery is characterised by the

formation of a close relationship with the woman which is seen as pivotal in providing individualised care and for monitoring the well-being of the woman and her baby (Winter 2002; van de Kooy 2010). Garratt (2014) recently undertook a hermeneutic qualitative study exploring UK independent midwives' motives for becoming independent. Her research found that the midwives interviewed had left the NHS to work in a more holistic way in an effort to enhance the midwife-mother relationship. Her research illuminated that whilst the midwife-mother relationship was enhanced in independent practice, the midwives also faced difficulties. These comprised financial insecurity and the challenges of working with women who often have very complex health needs and "particular expectations of the midwife-client relationship" (Garratt 2014, p.2). She also reported how working flexibly with women to fulfil their individual care choices and decision making could place independent midwives in

"a position of potential vulnerability and leave them subject to professional criticism".

Independent midwives practice a caseload model of care which enables a close relationship to build between the woman and her midwife. This is not the case for the majority of midwives practising within NHS models of care, where continuity of care can be fragmented. It is acknowledged that there are caseloading models within the NHS. These are however not the norm. The independent model also confers the benefit of time. It has also been asserted that the practice and decision making of independent midwives do not have to comply with hospital protocols, guidelines and policies, enabling their ways of knowing to be more diverse (Winter 2002). Gaskin (1996) and Hayes and Flannery (2000) have argued that intuition is a legitimate form of knowledge for midwifery care and particularly so in the practice of independent midwives. They maintain that these midwives have the ability to care for women in a social milieu that sanctions intuitive knowledge without being

constrained by hospital protocols and policy. It has been attested that this has enabled them to develop areas of midwifery practice without constraint of the bio-medical model (Davis 1995; Davis-Floyd and Davis 1996; Gaskin 1996).

The assertion that intuition may be part of the unique relationship, or connection between the midwife and woman and that it is legitimised as an authoritative source of knowledge during independent practice justifies the focus of this study to be centred on the experience as it is lived by independent midwives in the UK. It has however highlighted aspects of this cohort of midwives' care including the difficulties and vulnerabilities they experience through working independently. This description of independent midwifery practice will provide context for the findings chapter.

This brief synopsis has highlighted how independent midwives prioritise their relationships with women, which provides the potential for intuitive knowledge. As they also are not subject to hospital guidelines, they have the freedom to practice more autonomously (Winter 2002; van de Kooy 2010) enabling other sources of knowledge to be utilised (Winter 2002). Whilst independent midwifery only represents a small minority of midwives, it is believed however that the knowledge gained from these experiences will illuminate intuition as a phenomenon in midwifery practice which will benefit midwives in all practice situations (Jefford and Fahy 2015). Further reference and discussion of this cohort group will be included in both the methodology and methods chapter (see section 3.2.3., p.84) and the findings chapter (section 4.2.1., p.122). This chapter will now conclude with a justification for the research and present the aims and objectives of the study.

The literature review has analysed some of the existing theories of the nature of intuition psychologically and its use as a potentially authoritative form of knowledge, in midwifery and nursing practice. A personal reflection has been undertaken to

acknowledge my interest and agenda concerning the phenomenon. The literature review has highlighted that whilst there is evidence of intuition as existing as a phenomenon, scant understanding of the details of its use or concrete descriptions of situated examples are available, particularly in midwifery practice in the UK. There is a dearth of literature exploring how midwives utilise intuition so it is hoped my study may bring to light more detailed descriptions of how this works in practice situations.

My study's purpose is to elicit rich descriptions with an aim to increasing awareness of the existence and situational use of intuition in midwifery practice in the UK. No studies could be found fulfilling this criterion fuelling the need and the justification for the study and its aims and objectives. The selection of a cohort of independent midwives has been justified and a brief synopsis of this model of care has been provided to further evidence this choice. The phenomenological question, aims and objectives and justification for the study will now be presented.

2.9 The Phenomenological Question

The concept and philosophical underpinning of the phenomenological question has already been introduced in chapter one (section 1.4, p.22). The phenomenon intuition has been debated at great length in the literature; however, what the phenomenon has lacked is clarity. From the process of delineating the phenomenon personally and within the conceptual literature review, the phenomenon under study has been conceptualised as: *independent midwives' experiences of utilising intuition as a form of knowledge in practice*. The phenomenological question is ideally placed to explore the 'whatness' of a phenomenon, its boundaries and position in the

lifeworld of midwives. This uniqueness justifies the study coupled with the dearth of research of midwifery intuition in the UK.

The phenomenological questions posed for this research are: 'what is midwifery intuition?' and 'how does it exist in midwives lifeworlds?' This reflects the methodological need to embed the research in our participation in life (Husserl (1931). The aims and objectives of the study will now be presented.

2.10 Aims and Objectives

The phenomenological question reflects the aim of this study which is to describe the essential structure of independent midwives' experiences of utilising intuition within their practice.

The objectives of the study are to identify:

1. what is intuition as experienced and utilised by the independent midwives and
2. what are the independent midwives' experiences of utilising their intuition within practice.

This chapter originally identified the phenomenon for investigation within this descriptive phenomenological study as *midwifery intuition*. It has through a conceptual review of the literature delineated and articulated the experiential phenomenon as: *independent midwives' experiences of utilising intuition as a form of knowledge in practice*. This has been achieved through exploring its extensive boundaries in nursing, its existence in midwifery, and its origins in psychology. This

conceptual review has illuminated a dearth of research within midwifery in the UK providing justification for this study. My interest, preunderstandings and agenda have been made explicit to enable personal reflexivity and transparency for the reader, in keeping with the descriptive phenomenological research methodology. This has provided the justification, phenomenological question, and aims and objectives for the study. The next chapter explores in depth the descriptive phenomenological methodology for the study.

Chapter 3 Methodology and methods

This chapter includes a rationale and exploration of the descriptive phenomenological methodology and an analysis of the research methods undertaken in this study. Included within the methods section are the salient elements of exactly how each research stage was undertaken, utilising examples from the study to demonstrate transparency and rigour. This comprises recruitment, data collection, or gathering, and data analysis. Inclusive within this chapter will be a section which explicates and analyses the ethical considerations of the study and to provide context to the timing of the research, the timescale of the study will be presented. Before exploring the methodology however, it is important to clarify the exact meaning of the terms methodology and methods which introduces the next section.

3.1 Methodology

3.1.1 Clarifying the terms methodology and methods

As the terms methodology and methods have been defined in conflicting ways within research literature a recognised standard definition is required (Carter and Little 2007). Methodology has been defined as the philosophical framework that must be assimilated by the researcher so the principles and assumptions of the particular approach are both described clearly and justified (Schwandt 2015). Conversely, methods refer to the research techniques and procedures for gathering, analysing and presenting the data of the research (van Manen 1990).

Carter and Little (2007) assert that epistemology, methodology and methods should provide the structure for preparation and implementation of qualitative research. The methodology that is chosen must be defensible from the philosophical and epistemological positions that guide the study. Schwandt (2001, p.71) has defined epistemology as: “the study of the nature of knowledge and justification” and similarly, Carter and Little (2007, p.1317) as the theory and: “justification of knowledge”. Epistemology shapes the conceptualisation of the participant in data collection and analysis. It is also key in the assessment of the quality of data and analysis and how the researcher communicates with the audience. In the simplest terms epistemology modifies methodology and justifies the knowledge produced (Carter and Little 2007). Having defined the terms methodology and methods the chosen methodology for the study will now be justified.

3.1.2 The rationale for utilising a descriptive phenomenological methodology

For this study, a research approach is needed to identify the essence of the independent midwives' experiences of utilising intuition within their practice. As the phenomenon under study is difficult to rationalise and define, measuring and generalisability of this phenomenon within the positivist paradigm would be inappropriate, a qualitative approach therefore, was chosen. Husserl (1931) maintained that by virtue of their capacity for consciousness humans are different from material nature; therefore require research methods that differ from a positivist approach. The qualitative research methodology seeks to understand the meaning of human action and questions phenomena as they occur in context (Schwandt 2000). This research paradigm would therefore fit the aim of the study: to increase understanding into the nature of the phenomenon 'intuition' as experienced by

independent midwives in their practice. Phenomenology has been chosen as a qualitative research methodology as it studies everyday examples of human life and illuminates 'the whatness' and essence of a phenomenon (Finlay 2011).

Other qualitative methods could have been selected such as grounded theory which:

"inquires about how social structures and processes influence how things are accomplished through a given set of interactions"

(Starkes and Brown 2007 p.1373)

or discourse analysis which explores :

"how knowledge, meaning, identities, and social goods are negotiated and constructed through language in use"

(Starkes and Brown 2007, p.1373)

or a narrative approach that focuses on:

"narrated texts that represent a whole life story or aspects of it"

(Wertz et al. 2011a, p. 5882).

It is however, my endeavour to describe the actual *experiences* of independent midwives and illuminate the phenomenon explicitly rather than construct a theory, or analyse identities or stories. As van Manen (2015, p.6) emphasises unlike grounded theory phenomenology does not "aim to develop theory". Similarly, unlike ethnography:

"Phenomenology does not aim to explicate meanings that are relevant to understanding cultures or social groups."

(van Manen 2014, p.6)

A phenomenological approach would therefore appear to lend itself best to this study. This study requires a methodology to explicitly describe a phenomenon that is not easily defined or understood. Phenomenology as a research methodology

can language things that are known tacitly but not articulated in depth (Finlay 2011). It is well-suited to describe phenomena that are not well understood or difficult to rationalise (Le Vasseur 2003) as Finlay (2011, p. 1) clearly states it enables a process of:

“making explicit the meanings we attach to our human experiences”.

It is the study of experiences (Streubert and Carpenter 1995); and aims to gain a deeper understanding of our everyday experiences offering the elucidation of plausible insights (van Manen 1990). As there is a dearth of awareness of the nature of intuition experienced by midwives, phenomenology offers a research methodology that asks for the very nature of a phenomenon, the essence (Husserl 1931). As van Manen (1990, p.100) defined it:

“Phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning of structures, of living experience”.

The phenomenological research method clarifies the meanings of phenomena experienced by individuals through the analysis of their descriptions (Drew 2004). It offers elucidation of the chosen phenomenon and illuminates the voice of people experiencing a particular phenomenon (Streubert and Carpenter 1995). In the proposed research the phenomenon under exploration is independent midwives' experiences of utilising intuition during their practice. It must be acknowledged that phenomenology is first and foremost a philosophy as well as a research approach (Seidman 1991), whilst this has been already been introduced in the first two chapters it is necessary to explore this more thoroughly to enable more in depth comprehension of the epistemological underpinnings of the methodology. It will also introduce the philosophical tensions between the Husserlian and Heideggerian schools of thought.

3.1.3 The philosophy of phenomenology

Phenomenological philosophers have been diverse both in their interpretation and application of the central issues of phenomenology (Moran 2003). It is founded in Greek origins in which the Greek word for 'phenomenon' translates to 'something which shows itself by bringing it into daylight' (Fleming et al. 2003, p. 114). A more contemporary interpretation of phenomenology has been asserted by the philosopher Dilthey (Churchill and Wertz 2015). Dilthey was concerned with the study of psychology and the unique issues that our own embeddedness with the world brought to this discipline (Todres and Holloway 2004). Dilthey was against the idea of an experimental approach in psychology and championed a method based on: "descriptions and understandings" (Giorgi 2009, p. 18). Dilthey considered that as humans we can never have the objectivity revered by the natural sciences as human interests are inseparable from "a pre-existing involvement in experiential life" (Todres and Holloway (2004, p. 79).

Husserl (1931) whilst being critical of Dilthey's psychologism was interested in Dilthey's descriptive emphasis and explored it philosophically into a more epistemological direction. Husserl (1931) observed in the early 1900s that the advance of the positivist natural science paradigm with its emphasis on technology had led to the standpoint that scientific means were the most superior method to obtain "the truth" (Dahlberg et al. 2008, p.30). Husserl (1931) asserted that this scientific ideal would create a dichotomy between science and the everyday world which rather than confer the benefits of science would lead to the dehumanisation of society. To ameliorate this dilemma Husserl believed that the world of every day experience could become the foundation of science and a valid resource for

philosophical thinking. Building on the works of Dilthey, Husserl (1931) believed that:

“description rather than explanation would be the best means for identifying the essential constituents of human behaviour”

(Churchill and Wertz 2015, p. 201).

Husserl (1900a) believed that the way to establish this was to go ‘*back to the things themselves*’ to identify fully the lived experience. Husserl maintained that in order to truly understand the nature of a phenomenon all personal prejudice must be eliminated. According to Heidegger (1962), a scholar of Husserl, this premise was burdened with categories of the natural science method, essentially the concepts of certainty and absolute clarity (Paley 1998). Heidegger (1962) asserted that Husserl’s preoccupation with natural science led to him missing the original phenomenon being studied. Conversely, Heidegger was interested in the nature of being (ontology) wherein “existence knows itself only in relation with others and other objects” (Fleming et al. 2003, p. 114). He believed that in comparison to nature there were a wide variety of direct experiences within consciousness and therefore no experience could be duplicated and was in its essence unique.

As Heidegger’s studies evolved he replaced the concept of knowing with that of understanding (hermeneutics) (Seidman 1991). His main work centred on an interpretation of ‘dasein’ which translates directly as ‘being there’ (Fleming et al. 2003, p. 115) For Heidegger, however, this concept also included self-awareness, belonging to the world and relating with others (Heidegger 1962). This controversy of phenomenological philosophical standpoints finds a similar dichotomy in phenomenological research. The lack of articulated method for achieving

phenomenological research coupled with the even greater challenge of comprehending the philosophical underpinning of such research represent the two major challenges for the researcher (Caelli 2001). It is however acknowledged that Giorgi (2009) has clearly designed a rigorous research methodology and methods for descriptive phenomenology.

As reflected within the philosophical debate much of this discussion within the discipline of phenomenological research stems around whether to use an interpretive (Heideggerian) or a descriptive (Husserlian) approach. This will be considered in the following section.

3.1.4 The debate concerning whether to underpin lifeworld research with a descriptive (eidetic) or an interpretive (hermeneutic) approach

Finlay (2009, p.10) maintains that all phenomenological research commences with “concrete descriptions” of the lived experience and is all descriptive in the sense that it: aims to “describe rather than explain”. She advocates that any research that does not have as its central feature a description focused on the lived experience cannot be considered phenomenology. While all phenomenology is therefore descriptive in nature a number of researchers and academics distinguish between descriptive and interpretative phenomenology (Finlay 2009). The main tension within the debate appears to be the level of interpretation the researcher undertakes during the data analysis as Finlay (2009, p. 10) clearly summates:

“Importantly, the phenomenological researcher aims to go beyond surface expressions or explicit meanings to read between the lines so as to access implicit dimensions and intuitions. It is this process of ‘reading between the

lines' which has generated uncertainty. To what extent does this approach involve going beyond what the person has said and enter the realm of interpretation?"

It is therefore necessary to explore both research methodologies and their associated philosophical underpinnings, specifically in terms of the level of interpretation, to offer insight into the most suitable genre for the study.

A descriptive phenomenological approach inspired by Husserl (1931) aims to reveal: "general meaning structures" of a phenomenon (Finlay 2009, p.10). Researchers stay close to: "what is given to them in all its richness and complexity" (Finlay 2009, p.10) and limit themselves to only making assertions that are underpinned by relevant intuitive validations (Giorgi 1985). This research methodology intends to elucidate direct exploration, analysis and description of participants' experiences (Streubert and Carpenter 1995). Husserl's original purpose was to elucidate the original experience by bracketing (or epoche) certain presuppositions thereby seeking to attain the genuine true essence of the phenomena (Ray 1994). This has however been more contemporarily defined as adopting a phenomenological attitude: an open and non-judgemental stance which puts aside certain pre-existing ideas and assumptions (Finlay 2011).

Interpretive phenomenology, conversely, does not seek to remove certain presuppositions as it considers them to be part of the essence of a phenomenon (Gadamer 1990). This research method was inspired by hermeneutic philosophers (Heidegger 1962; Ricoeur 1970; Gadamer 1990) who assert that we are inextricably embedded in the world and have an "inescapable historicity of all understanding" (Finlay 2009, p.10). Heidegger (1962) argued that at the heart of any phenomenological description is its interpretation, he maintains that this is not an

additional procedure to phenomenological method but that our very “being in the world” is inherent with interpretation or as Finlay (2009, p.10) asserts:

“We experience a thing as something that has already been interpreted”.

Other researchers and academics argue for a continuum between descriptive and interpretive phenomenology where the level of interpretation is variable (van Manen 1990; Finlay 2009). Langdrige (2008, p. 1131), in this tradition, argues for the lifting of boundaries between description and interpretation maintaining that such divisions are against the underpinning principles of phenomenology which: “prizes individuality and creativity”. Another approach is to adhere to a descriptive framework based on reduction and imaginative variation, however apply a personal emphasis. An example of this is Todres’ (2005; 2007) embodied lifeworld approach.

For the purposes of this research I wish to maintain consistency with the methodology of descriptive phenomenology and seek the essence of the independent midwives’ experiences and knowledge. I have chosen a descriptive phenomenological approach over interpretive as:

“It emphasises a return to reflective intuition to describe and clarify experience as it is lived”

(Ray 1994, p.118).

It is this level of reflection on the “visceral texture of the experience” that so fits the aim of the study to describe the midwives’ experiences, as is given to the interviewee, “pregnant with layers of implicit meanings” (Finlay 2011, p.3). Descriptive phenomenology also provides a logical framework which can elucidate phenomena which are difficult to define and clarify, such as midwifery intuition.

Giorgi (2009, p. 5) argues that phenomenology can provide a rigour for qualitative studies:

“The reason that phenomenology is often associated with qualitative practices in this era of science is that it is a philosophy that offers a certain logic for legitimating qualitative discriminations with rigour”.

Husserl (1931b) asserted that a phenomenon stands out from the lifeworld and there is a question concerning its “whatness” (Todres and Holloway 2004, p.84) or what exactly makes it what it is. In a search to answer this dilemma he conceptualised the notion of essences or the essential, distinctive individual qualities of a phenomenon.

The very nature of the phenomenon under study lacks clarity and is difficult to rationalise, a descriptive phenomenological approach will be utilised to provide an articulation of its essence. The Duquesne school of psychological research has provided a disciplined structure to ensure that individual detailed descriptions combine to create an: “articulation of a level of generality” considered to be relevant to the phenomenon (Giorgi 2009; Todres 2007, p. 8). This is known as a general structure or essential structure and involves a level of description enabling researchers to further their understanding of a phenomenon in a way that is generally applicable (Giorgi 2009). This includes how elements of the phenomenon function and interrelate (Giorgi 2009). Another factor that Giorgi (2000b) strongly advocates before embarking on a descriptive phenomenological study is the comprehension of the salient differences between phenomenology as a philosophy and its application as a research methodology which introduces the next section.

3.1.5 Utilising phenomenology as a research methodology

Giorgi (2000a, p.4) has made the important distinction of utilising phenomenology as a research methodology:

“Phenomenological philosophy is a foundation for scientific work; it is not the model for scientific practice. The insights of the philosophy have to be mediated so that scientific practices can be performed”.

Giorgi (2000b) maintains that whilst phenomenology can provide a foundation for a qualitative methodology it is not an exact model for research methods. The major modification Giorgi (2000b) advocates is that concrete descriptions of an experience are gained from *others* rather than undertaking a *personal* philosophical reflection on experience. This decision was originally made to defend the phenomenological research method from criticism. As the founder of the descriptive research methodology Giorgi states:

“when the method was initially introduced in the early 1970s, the psychological establishment was dead set against qualitative procedures and so it would have been an uphill struggle to justify such a procedure”

Giorgi and Giorgi (2003, p.247).

It is questioned however whether this concern is still contemporary with such qualitative research methods as auto ethnography considered a rigorous means of achieving self-exploration (Qutoshi 2015). This study is however focused on the experiences of others.

Giorgi (1997, p. 21) also emphasises that descriptions from participants are acquired “from the perspective of the natural attitude”. Giorgi (2009, p.87) has described this perspective as the:

“attitude of everyday life, the attitude that one displays in the everyday world where most things are simply taken for granted”

This study fulfils the criteria that Giorgi (1997) has advocated as descriptions are achieved through data gathering of midwives' experiences. It similarly recognises the importance of obtaining descriptions from the natural attitude from participants. This is further explicated and evidenced in section 3.2.7, (p.100) Another salient difference between phenomenology as a philosophy and a research methodology is that Husserl's (1931a) original philosophical creation of an essence was intended to provide a level of generality that was universally applicable. Whilst this may be applicable within the physical world, when investigating the qualitative dimension of human experience however:

“where complex human experiences straddle the variations of unique Individuals, culture language and many other contexts essences can never be context free and therefore are applied within contexts rather than on a universal level”

(Todres and Holloway 2004, p. 89).

The final major difference is that throughout the data gathering and data analysis stages the researcher remains attuned towards the perspective of their own discipline, when looking for meanings (Giorgi 2009). This was adhered to within the study by attuning to the midwifery meanings in the descriptions.

The descriptive phenomenological research method will provide a rigorous means of explicating the phenomenon fulfilling the scientific concern, what remains however is a concern for the communication of the research findings which introduces the next section.

3.1.6 The communicative concern

One of the central concerns of qualitative research is to produce a feeling of understanding for the reader (Todres 2007). It is of utmost importance for this study to generate this comprehension or resonance with the research topic as the central concept of the phenomenon: the use or practice of intuition, by its nature is not easily comprehended. Whilst the formation of the essential or general structures provides the framework for the phenomenon, there is however the possibility that through this process the richness of individual descriptions may be lost. Todres (2007, p. 47) has referred to this notion of richness as an aesthetic dimension or 'texture' of an experience in which:

“what is revealed has the possibility of being personally appropriated; that is, that it can be empathically understood as something that is within the realm of human participative experience”.

This 'texture' provides the reader with not just the theoretical structure of a descriptive approach but the provision of a variety of meanings that may serve to underpin the readers' own actions in relation to the phenomenon. As the aim of this research inquiry is to improve midwifery knowledge and individualised midwifery care, the findings will be essentially communicated to midwives, midwifery students and educationalists. It is therefore vital that the findings convey the variety of meanings of the phenomena to enable a creation of resonance within their own practice. To provide a means to meeting this aim a further phase of research analysis was undertaken. This involved Todres' (2007) 'embodied enquiry' approach, which utilises the descriptive phenomenological research approach and its formation of general structures, however subsequently modifies this to:

“communicate the findings in more evocative and empathetic ways”

(Todres and Galvin 2006, p.51).

This approach utilises the phenomenological rigour of Giorgi's (2009) research method, however pays attention to the aesthetic dimension of the phenomenological description balancing both scientific and communicative concerns (Todres and Holloway 2004). As this embodied discipline has its roots within philosophy, it is vital to demonstrate clarity of methodology by exploring its epistemological underpinnings.

3.1.7 Embodied enquiry

The central aim of embodied enquiry is to evoke the nature of lived experience through language (Todres 2007). It seeks understanding for its reader by articulating knowledge of practice that is both personally transformative and intersubjectively humanising (Todres 2007). This approach is based on Gendlin's (1991) philosophy of the implicit. Gendlin has been in debate with the phenomenological standpoint for a substantive period. His apprehensions dwell with a communicative concern that the construction of an essence is too static and removed from the realities of the lifeworld. Todres (2005; 2007 p.3) has championed Gendlin's concerns and in his exploration of embodied enquiry asserts that phenomenology can ground human research to accomplish a union between the "head and heart". This concept is coined as 'embodied understanding'. Todres (2007, p. 5) proposes embodied enquiry as a means to seek this and further extols this method of inquiry as:

“an aesthetic pursuit that centrally requires the lived body as the place where intimate understanding of both experience and language happen”.

This understanding or interpretation has been further utilised as a way of “translating” health care research findings to enable practitioners to be more “sensitized to the human dimensions” of health care (Todres and Galvin 2008, p. 575). In this form of inquiry the descriptions of an experience are transformed into an evocative discourse to “awaken the aliveness of the meanings for others” (Todres and Galvin 2008, p. 575). This phase of embodied interpretation requires the researcher to return to the general structures and seek both the embodied sense of meanings and words to evocatively convey these meanings or embodied understanding (Todres and Galvin 2008). A further stage to address the communicative concern and provide more context to the findings was the addition of a composite description, this is further discussed in the methods section (see section 3.2.1.2, p.110).

This section has provided a rationalisation and explanation of the study’s methodology. The challenge within this doctoral research is to find some level of balance in communicating the structure and texture of the phenomenon. The articulation of general structures will enable communication of the essential elements of the phenomenon. The texture of the phenomenon can then be realised by providing a narrative movement that is communicated by poetic, evocative words encapsulating the embodied understanding of the midwives’ experiences (Todres 2007, p. 57).

Returning to the scientific concern or the rigour of the study this will be explicated in the next section, it is however acknowledged that throughout the research this is apparent through ongoing transparency and reflexivity and an audit trail of utilising the underpinning methodology of the study.

3.1.8 Rigour and reflexivity

It is acknowledged qualitative research has as its focus the phenomenon and its main aim is to increase knowledge, however one commonly held principle by the qualitative paradigm is that research is relational. Wertz et al. (2011a, p.84) define relational inquiry as research that:

“inevitably includes and expresses the orientation, methods, values, traditions and personal qualities of the researcher”.

An essential part of the rigour for qualitative research therefore is self-disclosure and reflexivity by the researcher. Reflexivity is an integral part of ensuring not only transparency but also quality within qualitative research inquiry. Finlay (2002, p. 531) has defined reflexivity as a process where:

“researchers engage in explicit, self-aware analysis of their own role”

Reflexivity has been postulated as a process in qualitative research wherein the researcher adopts a process of continuous reflection on how their own “actions, values and perceptions” affect data collection and analysis (Lambert et al. 2010, p. 321). The researcher should therefore adopt an explicitly self-aware and self-critical manner when conducting their inquiry to explain how her or his experience has or has not influenced the research process (Payne and Payne 2004). This involves both a personal level in terms of being aware “in the moment” of what is influencing the researcher’s internal and external responses and an epistemological level in terms of being aware of the researcher’s relationship to the research (Dowling 2006, p. 13). I have kept a reflexive diary which has recorded to date all aspects of introspection during the research process. This has encapsulated self-reflection and awareness of the intersubjectivity between the role of me as the researcher and the

research participants and the phenomenon under consideration. This process of reflexivity has commenced with a preparatory pre-reflective personal dialogue of my existing views of the phenomenon under consideration. This has been illustrated within the literature review which has illuminated my personal, academic and professional interests. This has continued throughout data gathering when entering the phenomenological reduction. Finlay (2008) has described this as maintaining a phenomenological attitude which is considered to be one of the most important aspects in phenomenological research (Finlay 2008). This is depicted by Husserl's mantra that we should 'go back to the things themselves' (Dowling 2011, p.57). This process involves an attempt to look at the world anew whilst suspending certain pre-existing knowledge and adopting a reflective stance. This concept and its underpinning in Husserlian philosophy will be further analysed and explicated in the methods section.

My aim has been to continually reflect on methodological progression of the phenomenological and embodied approach itself during all phases of this descriptive phenomenological inquiry (Wall et al. 2003). I also wish to clarify that my role within this research study is that of phenomenological researcher and not as midwife or educationalist, it is however acknowledged that these roles have affected my knowledge and experience of the phenomenon and this has been made transparent within the pre-reflection phase included within the literature review. In any discussion of methodology, the ethical dimension of using a research approach should be considered which introduces the next section.

3.1.9 Epistemological ethical Concerns

The advent of qualitative research has introduced new principles in research ethics. This extends beyond the usual tenets of informed consent; anonymity and confidentiality. Of central interest and concern is how power and politics relate to the research (Wertz et al. 2011a). In the positivist research tradition, Wertz et al. (2011a) assert that the researcher is the centre of power, maintaining hierarchical distance from participants, however within the qualitative movement; the emphasis is on sharing power and forming collaborative relationships (Clarke 2006). The purpose within phenomenological interviewing is to derive shared meanings enabling the interviewee to co-create the data fulfilling this ethical concern. The details of this have been further explored in the next section which presents and analyses the methods of the study and in section 3.2.14 (p.114) which addresses the ethical concerns of the study.

3.2 Methods

The methods of this research are based on Giorgi's (2009) descriptive phenomenological research approach and Todres and Holloway's (2004) interpretation of it. This entails "articulating an experiential phenomenon of interest for study" (Todres and Holloway 2004, p.80); "description", "reduction" and construction of "essential structures" (Giorgi 2009, p.6,) to address the scientific rigour of the study; and an embodied interpretation of the essential structures to address the communicative concerns of the study (Todres 2007; Todres and Galvin 2008). These different methods will now be analysed and explicated utilising examples from each phase of the study to provide transparency for the reader. The first process or 'articulating a phenomenon' will now be presented.

3.2.1 Articulating a phenomenon

Todres and Holloway (2004) emphasise the importance of both delineating the phenomenon and subsequently clearly articulating the question to be posed. The phenomenon under inquiry is: *independent midwives' experiences of utilising intuition as a form of knowledge in their practice*. During this stage the researchers "acknowledge and make explicit their initial agenda" (Todres and Holloway 2004, p. 84). As already stated, this is underpinned with the philosophical assertions of Husserl (1931) who maintained that the beginning of our understanding is informed by our human "embeddedness and participation in experiential life" (Todres and Holloway 2004, p.83).

Much of my interest and the delineation of the phenomenon however has already been analysed and presented within the literature review. Todres and Holloway (2004, p.84) assert this stage includes sensitivity to certain personal “historical, professional and community contexts”. The personal reflection of the literature review I believe has served to evidence this stage by illuminating my professional and theoretical interests and describing the context of personal interest for the phenomenon.

Having articulated and delineated the phenomenon, the next stage is description through data gathering. Prior to this phase however, recruitment, sample type and size for the description are now presented.

3.2.2 Recruitment

My original intention was to recruit eight to ten independent midwives. The rationale for this number will be considered in the next section. Recruitment was planned via an advertisement on the Independent Midwives Association’s (IMA) website, however prior to placing the advertisement a number of independent midwives expressed an interest in being interviewed for the study. This occurred when I attended a study day where some independent midwives were present. Two independent midwives approached me after an introductory table-top session detailed that my field of research interest was independent midwives’ use of intuition. No discussion was undertaken of the study details and they were informed that they would only be contacted after successful university research governance ethical consent was achieved. Recruitment would then take place following

provision of an information sheet and consent form. Both of these midwives were subsequently recruited.

The remaining five of the midwives were recruited by posting the information sheet (see appendix one, p.315) on the IMA's website. All midwives were sent the information sheet and consent form which was discussed and signed prior to the commencement of the interview (see appendix two, p.318). Seven independent midwives were interviewed in their homes across the South and Midland areas of the UK during 2012 and personal transcription of the interviews were then completed.

Transcriptions of the data were subsequently returned to the interviewees for confirmation that they agreed their interview transcript to be used for data analysis. Areas where the interviewees may have compromised their own or their clients' identities were highlighted on the transcripts and are not included within the final thesis or dissemination of results to preserve anonymity of all involved. All interviewees agreed for the transcripts to be used for the study, one interviewee asked to see and agree any of her personal quotes, however only if they were included in any future publications. The method of research sampling will now be presented commencing with a consideration of the sample size.

3.2.3 Sample

It is not possible to give recommendations about how many participants should be included in a phenomenological study; this should be individually decided when there are no more emerging themes or insights (Colazzi 1978). Smythe (2011)

recommends between five to eight participants for a masters study or twelve to twenty for a doctoral study, she fails however to give a justification for these figures. Giorgi (2009) asserts it is not the sample size that is important but the depth of the description of the phenomena. Giorgi (2009) advocates that for some research inquiries one participant can be sufficient, for other more complex research phenomena however, there need to be enough participants to identify a range of variation. To achieve this end he recommends at least three. A figure of eight to ten was proposed, due to the complexity of the phenomenon, it was however decided that this was flexible in terms of the depth and range of the emerging data. At the completion of the seventh interview it became clear that data collection was sufficient for my purposes within the context of my phenomenological interests. Before describing exactly how this occurred however, it is first necessary to describe the diversity or variation of the research sample. This will be briefly described and definitive details are presented in a table (see figure 3:1, p.87).

The purposive sample of seven independent midwives had a varying amount of experience working within both the NHS settings and independently. All had however, worked in both practice arenas. The number of women the midwives caseloaded annually has been included to give context to their level of experience within independent practice. As can be seen from the table below all of the midwives had a wealth of experience. This was not a requirement that was requested however no newly qualified midwives volunteered for the study. This will be further discussed in the final conclusion chapter, in the section detailing the strengths and limitations of the study (see section 6.1, p. 283). It is recognised that the sample however contains a range of experience. All the midwives were at the time of the study contracted independently to women. Some however had other means of income, such as private antenatal parent education classes, an NHS bank

contract or a teaching contract in the NHS where they facilitated education to post-registration midwives. Data gathering was undertaken from this self-selected purposive sample to ensure rich descriptions were obtained of the phenomenon under inquiry.

Figure 3:1: Demographic details of sample

| Midwife's pseudonym | Years of experience within the NHS | Years of experience within independent practice | Average caseload per year |
|---------------------|---|---|---------------------------|
| Fiona | 7.5 (18 months as substantive contract, 6 years as bank contract) | 7 | 30 |
| Louisa | 6 | 6 (including private ante-natal classes) | 16 |
| Eleanor | 11 | 6 (including private ante-natal classes and a teaching contract with the NHS) | 15 |
| Debby | 5 | 9 | 15 |
| Dee | 10 | 7 | 15 |
| Polly | 11 | 21 | 20 |
| Catherine | 6 | 6 | 10 |

In purposive sampling, “relevance is more important than randomness” (Shneerson and Gale 2015, p. 848) and so events, incidents, and experiences rather than diversity are characteristically the objects of sampling (Robinson 2014). Purposive sampling is determined by the direct and personal knowledge individuals can yield about an experience (Sandelowski 2007). Data gathering ceased when similar experiences were occurring within the interviews. After the seventh interview, I experienced an overwhelming feeling of personal knowing that one more interview would have been too many (Smythe 2011) as the following entry from my reflexive journal illuminates:

Following this interview I was struck with a sense that this was the end of my data collection. Whilst the interviewee shared valuable descriptions of experiences there was a sense that these were similar to previously described facets of the phenomenon.

This decision was made following much reflection. During data gathering, elements of the phenomena under investigation were becoming repetitive. The final interview did not offer any new insights and I strongly intuitively felt as if this was the end of data gathering stage. I did however want to rigorously ensure this was the case, and so I read all of the completed transcriptions. What I found from this endeavour was that the individual experiences were different but the phenomenon appeared the same. Further recruitment may have increased the number of times the variations of the phenomenon occurred, however as Giorgi (2009) asserts, phenomenological research seeks to identify the depth of an experience and what exactly constitutes it, rather than the quantitative dimension of experiences. A phenomenological study is not looking for data saturation but depth of meaning:

“The idea that you keep looking until you have saturated your material, until your data are saturated, does not make sense because there is no saturation point with respect to phenomenological meaning.”

(van Manen 2015, p. 5).

As stated the decision to cease data gathering was not taken lightly and was supported with a reading of all the completed transcripts which demonstrated sufficient concrete description of the phenomena (Giorgi 2009). The descriptions gathered were rich and illuminated the various side of the phenomenon. This decision was coupled with an ethical concern that each interviewee should be honoured by enabling enough time to be available to work intensely with their data and the limitations of a part time doctoral study. It is however acknowledged that the confirmation of cessation of data collection cannot be fully realised until data analysis is undertaken (Giorgi 2009). Having presented the recruitment and purposive sample selected it is now necessary to analyse the description and data collection or 'gathering' stage (Finlay 2011).

3.2.4 Description and data gathering

3.2.4.1 Description

The description stage has already been provisionally described in both the introduction and background (see section 1.4, p.22) and the literature review chapters (see section 2.7, p.55). The description stage has been defined as a formulation of a phenomenological question that will encapsulate the experience or "invite lifeworld descriptions from others" (Todres and Holloway 2004, p. 85). This process must include disciplining certain preconceptions to create an "experience near" question (Todres and Holloway 2004, p.85). This is philosophically underpinned by Husserl's (1931a) concern that inquiry should be embedded within the lifeworld. To maintain a phenomenological attitude it is imperative that the researcher "stands back" and asks an open phenomenological question of the

research topic (Todres and Holloway 2004, p.85). In the context of this study, this question was:

‘What is the experience to which intuition may refer?’

The term intuition may have a theoretical perspective however it is important to delineate what experience it actually refers to. For this reason the question was formulated more specifically into the following: ‘what is intuition?’ and ‘what are the independent midwives’ experiences of utilising it in their practice?’. The formulation of the questions for this study to explicate the phenomenon took extensive discussion and personal reflection to ensure there was a shared comprehension of the phenomenon. This involved the naming and delineation of the phenomenon which has already been presented and described at the conclusion of the literature review. The discussion particularly centred on how the term ‘intuition’ could possibly represent a multiplicity of meanings derived from the literature review and personal interest of the phenomenon. It was decided finally however, that other terms may be misunderstood, for example, embodied or empathic knowledge or suggestive of definition, for example, gut reaction or tacit knowledge. It was also decided that ‘intuition’ was an umbrella term which appeared to represent the phenomenon’s multifactorial nature.

Husserl (1931b) provides some helpful advice in formulating a lifeworld question within his philosophical view that all life experience is situated. This is termed “intentionality” (Todres and Holloway 2004, p.86). Intentionality refers to the relationship between a person and an object or event with their experience, or as Dahlberg (2011, p. 21) clearly states:

“One’s directed awareness of something in one’s world”.

Todres and Holloway (2004, p. 86) relate to this in terms of consciousness and experience, conceptualising that these are never just inner experiences but are

“interactional” and related to “relationships within the world”. Research questions must therefore be phrased to elicit a lifeworld experience.

To achieve detailed descriptions of the phenomenon under study, it was initially planned that the following questions would be asked of independent midwives:

‘Can you describe in your experience what you consider intuition to be’
and

‘Can you describe an experience in which you felt moved to act on your intuition when caring for a woman during your midwifery practice ’

It was subsequently decided however that the first question might elicit more theoretical responses which are not appropriate to a phenomenological study. Giorgi (2009,p.121) emphasises that it is important to pose a question that invites the interviewee to focus on a specific situation she or he have actually experienced or else interview data elicited may be too “abstract, too general or made up of opinions or attitudes”. The first question was therefore subsequently rejected. The second experiential question became the focus of the study. For any data gathering phase in a phenomenological study to be rigorous the researcher must enter the phenomenological attitude. This will now be explicated utilising Husserlian philosophy to underpin the analysis. For clarity it is of note that Husserl coined three terms: phenomenological reduction (or attitude), epoche and bracketing. These terms however he used interchangeably (Le Vasseur 2003). An adoption of the phenomenological attitude commences with the data gathering. To enter the phenomenological attitude the researcher is required to change their attitude from the natural attitude. This will be explored in the next section.

3.2.5 Adopting the phenomenological attitude

It is necessary to define the differences between the natural attitude and the phenomenological attitude. Husserl (1931) first identified the distinction which is key to comprehending our understanding of the world. It was the philosopher Dilthey however who earlier conceptualised the nature of our understanding and the unique problems we encounter when scientifically studying ourselves (Todres 2004). Dilthey conceptualised how we are already enmeshed within the life we are trying to comprehend as we are already grounded in and have a pre-existing life (Todres 2004). Husserl further identified this as the natural attitude. Husserl (1931, p.101) described the natural attitude as the standpoint of an individual's everyday life:

“Through sight, touch, hearing, etc., in the different ways of sensory perception things are *for me simply there*, in a verbal or figurative “present” whether or not I pay them special attention by busying myself with them”

This includes a world rich with human endeavour, relationships, physical objects, experiences and obligations (Le Vasseur 2003). Husserl (1960a) described entering the phenomenological reduction as changing one's consciousness from the natural attitude to the philosophical attitude. Husserl famously coined this process as returning '*back to the things themselves*'. This is when an individual's natural attitude towards the world is bracketed (Le Vasseur 2003). Husserl asserted that bracketing is suspending an individual's natural assumptions or world view so:

“what is essential in the phenomena of consciousness can be understood without prejudice”

(LeVasseur 2003, p. 411)

In the descriptive phenomenological research project, when entering the phenomenological attitude the researcher immerses themselves into the world of description by suspending personal and professional preconceptions about the phenomenon (Todres 2005). The phenomenologist's first task is to "bracket out" these beliefs or preconceptions so the researcher can:

"attend genuinely and actively to the participant's view"

(Finlay 2002, p. 537).

My own preconceptions about the phenomenon have already been reflexively described and illuminated in the literature review chapter. This is not however the completion of bracketing or epoche . As Finlay (2009, p. 8) comments:

"Novice researchers often misunderstand this process of bracketing as an initial first step where subjective bias is acknowledged as part of the project to establish the rigor and validity of the research."

The process of bracketing however is engaged in throughout the research process. The process of personally entering the phenomenological reduction will be reflectively analysed within the next section which presents the data collection phase of the study.

3.2.6 Data collection or gathering

The data collection phase in a phenomenological research study has been termed as "gathering" rather than collection. Dahlberg et al. (2008, p. 172) define this term as an activity wherein researchers seek:

"descriptions, utterances, characterizations, narrations, depictions and other possible expressions of studied phenomena"

Data gathering was undertaken by semi-structured interviews of a cohort of seven independent midwives. This fulfilled the second stage of the descriptive method of gathering experiences that are examples of the phenomena. Giorgi (2009) maintains that what is needed from a phenomenological interview is as concrete a description as possible that the interviewee has lived through.

Phenomenological interviewing consists of in-depth open dialogue and questions which maintain a focus on the experience and recreate many dimensions of that experience (Giorgi 2009; Kleiman 2004) providing a richness of detail and context that shape that experience (Clarke 2006). It remains however that even phenomenologically orientated questions may reveal 'too abstract' responses (Giorgi 2009, p.122). During my data gathering, paying heed to Giorgi's concerns, I remained observant of whether the interviewees were revealing an aspect of how they were present in the situation. Giorgi (2009, p.122) asserts that if this is not the case then it is perfectly legitimate for the interviewer to direct them back to this focus. On a number of occasions interviewees did become more abstract, for example describing others' experiences or theorising their own experience. This was predominantly notable in my first interview with Fiona. Despite utilising a lifeworld evoking question concerning experiences, some of her interest of the phenomenon was theoretical and enmeshed with her colleagues' views. During these events I attempted to direct her back to her individual experience. I was however mindful to be directive rather than 'leading', as the latter could be construed as the researcher attempting to elicit specific responses and introducing bias (Giorgi 2009). In subsequent interviews, I was mindful to explain the methodology in brief to the interviewees emphasising the importance of eliciting their detailed personal experiences and not their theoretical interests or others'

experiences. It is acknowledged that this still happened on occasions however this enabled a certain amount of context to enrich the midwives' descriptions.

To stay faithful to the spirit of phenomenological research I placed emphasis on the co-operative research-interviewee relationships and open-ended dialogue with the aim of fully appreciating the midwives' lifeworld experiences (Dahlberg 2011). I made efforts to make the interviews as flexible as possible by asking clarifying questions in order to illuminate the full meaning of the midwives' descriptions (Bondas 2011). These I ensured enabled clarity of the description, rather than leading the interviewee, examples are as follows:

“Can you possibly describe that in more detail?”

and

“When you said ‘felt’ can you describe exactly where and how you experienced this feeling?”

Finlay (2011, p. 29) asserts that researchers frequently fail to pose follow-up questions, and in the process are unsuccessful in eliciting: “more descriptions in detail” and as a consequence fail to present “more lifeworld variants”. Finlay (2011, p. 197) asserts a way forward and advocates that researchers should aim to “get into the moment” to elucidate how the phenomenon is experienced by the person: “emotionally/cognitively/bodily and in the context of their life”. As far as possible during the interviews I attempted to adopt this embodied approach, and attempted to simultaneously dwell with the knowledge the interviewees gave whilst probing for meanings. This is described as being phenomenologically orientated during the interview process (Finlay 2011). Throughout the interview process I paid heed to three processes to enable phenomenological orientation: “openness”, “empathy” and “attentive listening” (Finlay 2011, p.208). Openness was achieved by

suspending certain pre-suppositions of the phenomena, this has been interpreted as being objective, however Finlay (2011a, p. 208) maintains that this is an attitude of openness and “receptivity”, accomplished by emptying the self in order to be “filled” by the other. The process of clarifying and narrating my personal interests in the phenomenon made it easier to be open to the emerging phenomenon. My interests and the conceptual literature review were put to one side with ease. One example of this is when a number of the interviewees described their intuitive knowing as being perceived through verbal and non-verbal cues. It was not until the writing up of discussion chapter that I realised that this facet of the phenomenon had been mentioned, albeit superficially within the literature (see section 2.4, p.41). Its emergence however in the course of obtaining the descriptions appeared new, naïve and fascinating (Giorgi 2009).

Empathy was accomplished by attempting to develop an attitude of “being with the other” in a relational space (Finlay 2011, p. 208). Finlay (2011) refers to this as engaging reflexively with both our own body and our intersubjective encounter with the interviewee. I became aware of my own emotions utilising this technique, feeling excitement, wonder and sadness. This was particularly resonant with Louisa, one of the interviewees. During Louisa’s experience of intuition and bereavement I became aware of my own silent tears and Louisa noticed and handed me a tissue. This was a poignant example of “being with the other”.

Attentive listening is a combination of both openness and empathy. Having skills as a midwife and an educator I was competent in being open and receptive of others. I found this technique enabled me to “slow down” and dwell with the interviewee, Finlay (2011, p.209) describes this as a process of critical listening involving “curiosity, contemplation and compassion”. I attempted to reside with the

phenomenon at all times however, I acknowledge there were occasions when I became captivated by the various experiences that were being related and it took sheer willpower to prevent myself becoming “subject orientated” (Hallberg et al. 2010, p. 4897). This is where the researcher can lose focus on the phenomenon and become distracted by the subject, in my case the clinical issues involved in the description rather than the experience in all its wholeness:

“There is a big risk if we are captivated by the various individual experiences which are reported, especially the hard or otherwise extreme ones; that is, if we are too subject oriented. A key thing then is to move from the nuances of personal experiences to the essential features of the phenomenon—to be phenomenon oriented”

(Hallberg et al. 2010, p. 4897).

One such example occurred when Polly described an experience when she utilised her bodily felt form of intuition to help advise a couple to have an emergency caesarean section. She related how later during the woman’s caesarean section, within this experience, the placenta was affected which confirmed her intuition had been correct. At this juncture I had a desire to explore more about the clinical issues relayed in this description, however stayed with Polly’s experience which subsequently revealed rich details of how she integrated her experience within her lifeworld as a midwife. This enabled greater depth of the experience to emerge, thus demonstrating how I made the effort to pay enough attention to the individual’s experience to elicit the:

“richness of detail and context that shape that experience”

(Finlay 2011, p. 113)

rather than deviate on a subject or clinical based trail.

Many lessons were learnt during the interviews. One of the main ones was the skill of returning the interviewees to the phenomenon without interrupting their narrative or leading the interviewee. The other lesson was to have the ability to respond appropriately to the interviewees. It was challenging to find the level between giving the interviewees positive feedback that their narratives were relevant and interesting and leading them to believe this was *exactly* the data that was preferential to me. Sides of the phenomena were illuminated that were unexpected and provided new insights to the phenomenon, being phenomenologically inclined however, I was mindful to let these descriptions unfold. This was particularly evident when one of the midwives described the perception of a dream; again, I focused on the rich details of all of their experiences rather than probing this particular one.

The interviews terminated when the interviewees had nothing more to tell. This was usually signposted by a period of silence. I would then pose a final question as to whether they wished to add anything else (Bondas 2011). Other elements concerning the ethics of data gathering are presented in the ethical considerations section (see section 3.2.14, p.114).

The interviews were tape recorded and personally transcribed. At first consideration, transcribing appears to be a straightforward technical task; however, the process involves decisions about the level of detail to include (Bailey 2008). This includes whether or not to omit:

“non-verbal dimensions of interaction, “data interpretation (e.g. distinguishing ‘I don’t, no’ from ‘I don’t know’) and data representation (e.g. representing the verbalization ‘hwarryuhh’ as ‘How are you?’)”.
 (Bailey 2008, p.127).

It can be concluded from this that transcripts are not necessarily neutral recordings of interviews however, include some level of a researchers' interpretations of data. In the interests of transparency and rigour I include an excerpt of an interview with Debby detailing the degree of transcribing utilised:

Debby: Ok, in that situation, um I was caring for a primip who had a breech baby on board and was planning a a home birth um, and I remember I woke up one morning and I just felt I've got to go where she lived she was in (place area) so quite,

Me: *Hmm*

Debby: quite some distance from me and I just thought I've got to go, and, and it, this was very early in the morning and I just got up and drove to her house and sat outside until it felt like a reasonable time that I could knock on the door and (laughs).

From this excerpt it can be seen that the original interview has been described exactly as it was recorded verbatim. Repeated words and some of the narrative however make it at times difficult to follow. For this reason, whilst the original recordings were transcribed verbatim to preserve their originality, data excerpts in the findings chapters were slightly revised by deleting repeated words, and adding punctuation to aid comprehension. Laughing and other expressions and pauses were included as they may hold meaning when describing the data. What was removed however was the mentioning of place names to provide confidentiality. The following excerpt presents how the transcription was later utilised to illustrate the findings chapter:

"I was caring for a primip who had a breech baby on board who was planning a home birth. And I remember I woke up one morning and I just felt I've got to go: she lived quite some distance from me. And I just thought I've got to go. This was very early in the morning and I just got up and drove to her house and sat outside until it felt like a reasonable time that I could knock on the door." (laughs) Debby.

Any emotional expression, such as laughing, sighing or crying was included to enable transparency for the reader and a window in which to fully appreciate the lifeworlds of the midwives. Staying true to the spirit of descriptive phenomenology no attempt was made to interpret their emotions. It did however enable the depth of meaning to unfold from their words (Dahlberg et al. 2008). To provide transparency, an example of a transcript is presented in appendix five (p.331). The transcript details are included within the 'meaning units' column.

This completes the data gathering phase which resulted in rich descriptions of experiences from the midwives' lifeworlds. Once the data has been collected and transcribed, it is ready for analysis (Giorgi 2009) and is then utilised for further "understanding and evidence" in the data analysis stage (Todres and Holloway 2004, p. 86) which introduces the next section.

3.2.7 Data analysis

This section will consider the data analysis phase of the descriptive phenomenological research method and the formulation of the general structure. It will then present a further stage of data analysis: a composite description and an embodied interpretation. The presentation of the data analysis will again include analysis of personal examples from the inquiry of how exactly these stages were undertaken in the interests of transparency. Each stage of the data analysis will be presented and analysed including its underpinning, Husserlian philosophy to provide epistemological rigour for the study. The data analysis is based on Giorgi's (2009) phenomenological research method and Todres' (2005) adaption of it and comprised the following phases: reading the scripts for a sense of the whole;

discrimination of meaning units; transformation of the participant's expressions into phenomenologically sensitive expressions and construction of the general structure. All phases of the data analysis are undertaken within the phenomenological attitude or reduction. "Reduction", or "intuiting and testing the meanings of the experience" aims to articulate transferable meanings that can help to elucidate the phenomenon by establishing what is typical of the phenomenon (Todres and Holloway 2004, p.88). The first part of the data analysis will now be presented.

3.2.8 Reading the scripts for a sense of a whole

Prior to this stage the phenomenological researcher enters the phenomenological reduction Giorgi, (1994, p. 212) describes this as bracketing which he asserts:

"involves a process whereby one simply refrains from positing altogether; one looks at the data with the attitude of relative openness".

The purpose of this process is in order to become:

"as faithfully present to the intrinsic intelligibility of the meaning of the narratives"

(Todres 2005, p.111).

Analysis commences with re-reading of the transcripts. The transcripts were read for a sense of the whole to see the meanings of the phenomenon concerning the independent midwives' experiences of using intuition in their practice. Giorgi (2009) asserts that whilst it is the researcher's task at this stage to discover: "a sense of the entire description", clarification or making the global sense of the meanings more explicit is left to a later stage. When re-reading the scripts, entering the reduction was personally refreshing as I could feel a sense of focusing completely on the phenomenon and how the midwives individually utilised their intuition. Each

transcript had a sense of wholeness and their individual experiences had uniqueness. During this process, although I could start to perceive similarities and differences between the descriptions I observed these rather than let them colour my overall sense of the uniqueness of the individual script. What I was struck by was my own emotional reaction to each script as the following excerpt from my reflexive diary relates:

It is such a joy re-reading the transcripts, at times I feel tearful noticing the depth of the midwives' passion and dedication to their practice. This however I bracket, realising this is my reaction and emotion, not theirs. This helps me focus on the phenomenon arising not from a place of emotional coldness, but gently watching each narrative unfold, gradually gaining a sense of each midwife's artistry.

This realisation enabled me to suspend my own reactions aiding the process of the phenomenological reduction. My emotional reaction however could also be considered another part of the phenomenological process as van Manen (1990, p.129) asserts:

“Textual emotion, textual understanding can bring an otherwise sober-minded person (the reader but also the author) to tears and to a more deeply understood worldly engagement “.

Having completed the re-reading of the scripts, the next step Giorgi (2009, p. 129) identifies is the determination or “discrimination” of meaning units (Todres 2005, p. 112).

3.2.9 Discrimination of meaning units

During this stage each description is divided into meaning units. This has involved re-reading each transcript and marking each time a change of meaning occurred.

Again the researcher enters the phenomenological reduction and attends to the shifts of meaning with reference to the phenomenon under study. In pursuing this stage I noticed that meaning units were not always determined with individual sentences, as sometimes the sentences were neutral to the phenomenon. As Giorgi (2009) relates sentences are units of grammar and not necessarily sensitive to the reality of the lifeworld. The following excerpt from Eleanor's transcript exemplifies this when she was explaining how her personal experience of intuition manifests within her:

“Something that comes from inside, and not a conscious thought.

It's not something that you think ooh, you know, or something you are immediately aware of, but it's just something that may be grows.”

In the excerpt the meaning then changed from describing an intuitive awareness to relating to what the feeling illuminated for Eleanor, as illustrated below:

“And sometimes with time as well you get a feeling as to whether something's going to turn out the way you're expecting it I suppose or how the woman is expecting it to turn out.”

At this stage the transcript remains intact until the next stage which involves transformation of the participant's expressions into phenomenologically sensitive expressions (Giorgi 2009, p. 130) or formulation of transformed meaning units (Todres 2007, p. 112). An example of a transcript containing the meaning units and the transformed meaning units is included within appendix five (p.331) to provide transparency and further elaboration for the reader.

3.2.10 Formulation of the transformed meaning units

Giorgi (2009, p. 131) has asserted that the “heart” of the method is inherent in this stage. In this research process meaning units undergo initial transformations to enable more “general and transferable insights” (Giorgi 2009; Todres 2005, p. 112). The researcher “interrogates” the meaning units and expresses the meanings of the lifeworld description (Giorgi 2009). Todres (2005, p. 112) clearly describes this process as posing the following questions:

“Within the total context of this protocol, what does a change of meaning tell me about the experience of the phenomenon in a more general way?”

And:

“How can I express this specific quality in such a way that it does justice to the concrete situation?”

Here the researcher may transform the language originally used by the participant to help provide more sense and meaning to the phenomenon. An example is provided below from Dee’s transcript. The following is the original verbatim description from Dee:

“And through the pregnancy that kept repeating, and I sort of I was aware of it but I, because it didn't have a definite shape, or a definite form or a definite, definite thing I didn't quite know what to do with it really.”

There were however particular nuances and qualities in this description that can be phrased in a more transferable and general way that pertain to the phenomenon.

This excerpt I then transformed into the following:

Throughout the pregnancy this felt sense continually reoccurred however Dee did not know how to react to it as it appeared indiscriminate.

This stage involved a continual process of reflexivity to ensure I was not utilising a personal interpretation of the midwives' narratives. Utilising a phenomenological attitude with such detail was at times easier as the descriptions contained elements of experiences that I had not previously experienced or researched. When the meanings of the phenomena were more complex I undertook a further transformation as suggested by Giorgi (2009). This is exemplified by the following excerpt from Polly from the original transcript when she described how a couple had been booked in for a caesarean section as their baby was small. Polly had however examined the woman's abdomen and realised that the baby had grown. At that point she suggested they still had the opportunity to birth at home when suddenly she received an intuitive message through her hands which were still on the woman's abdomen informing her that the women needed an immediate caesarean section:

"You know they were really up for it, that's what they were like and I got this really strong message through my hands that really nearly shot my hands off her abdomen. No, caesarean now!"

This transcription underwent the first transformation:

The couple wanted to go home and were enthusiastic to change their plans however at that point Polly received a communication through her hands that nearly made her remove her hands from the woman's abdomen demanding the woman had an immediate operative delivery

Whilst this transformation gave the meaning unit more clarity, it was necessary to further explicate a more general meaning. And so subsequently this version underwent a third transformation to enable a more specific meaning of the phenomenon:

The couple wanted to go home and were enthusiastic to change their plans, however whilst examining the woman's abdomen Polly received a very directional intuitive message which was recommending an emergency procedure.

I reflected that the words *directional* and *recommending an emergency procedure* provided a more generalised and midwifery focused meaning without utilising midwifery jargon or interpreting the meaning (Giorgi 2009).

Having completed this stage of data analysis the researcher continues and now undergoes a process of intuitively testing the meanings of the experiences to enable the creation of essential or general structures (Todres and Holloway 2004). For transparency, an example of the transformed meaning units are included within appendix five (see p. 331).

3.2.11 Formulation of the General Structures

This phase of the analysis illuminates possible meanings in a more general way and has been coined as the: construction of the general or essential structure (Todres and Holloway 2004, p.88). This theory of creating a level of generality differs however from the concept of generalisation within the quantitative paradigm which aims to produce findings that can be generalised across populations and settings (Kumar 2014). In phenomenological research general structures refer to:

“expressions of patterns or wholes that coherently make sense of the examples on which they are based”

(Todres 2005, p. 111).

These patterns are able to qualitatively distinguish the ‘whatness’ of a subject and how specifically the typical elements of a phenomenon function constitutively and

interrelate to form the unity of the experience (Todres and Holloway 2004). Husserl (1931a) described a level of generality that was absolutely applicable to every case. Todres and Holloway (2004) discuss that this concept may be more pertinent to natural science methods where naturalistic rules apply, however in a qualitative inquiry it is more appropriate to apply similar contexts to ensure clarity of a phenomenon. This demonstrates a further element of the differentiation between phenomenology as a philosophy and a research method.

The concrete steps of the formulation of the general structures involve a “synthesis” of the transformed meaning units into a consistent presentation of the “invariant themes” that occupy the different descriptions of the experiences (Todres 2005, p. 113). For the first time within the data analysis the researcher is required to compare different cases and participants’ experiences with one another. This was exemplified by one of the consistent structures of intuition which was entitled: ‘*kinds of noticing*’ or the ways in which the midwives perceived their intuition. This structure however had several variations. For example they would notice their intuition through ‘*the reception of verbal and non-verbal cues*’ (Giorgi 1997) or ‘*a bodily felt sensation*’.

The overall aim of this stage is to establish what is typical of the phenomenon. This typicality is not however taken for granted, it is then tested (Giorgi 2009). This process involves the researcher returning to the data contained in the individual participants’ descriptions, or parts, then returning the formulated general structure, or the whole. During this step I noticed that re-visiting my general structure would aid further comprehension of the parts and this in turn would help further refine the structure (Giorgi 2009). This is based on Husserl’s (1931a) discovery of essences and involves the researcher removing one aspect of the phenomenon to see

whether the structure is radically altered, if this is the case, then the constituent or part is considered essential. This process has been called: 'free imaginative variation' as Giorgi (2009 p.69) clearly defines:

“Free imaginative variation requires that one mentally removes
an aspect of the phenomenon that is to be clarified in order to
see whether the removal transforms what is presented in an essential way.”

From my own research, an example of this occurred when two of the midwives described visualising abstract images. Whilst the majority of the constituents were experienced by all of the midwives, the visualisation of images was limited in the descriptions. Removing this from the general structure however changed a vital part of it however and limited the constituents. As Giorgi (2009, p.70) states:

“if the given appears radically different because of the removal of a part,
It is leaning towards being essential”.

The descriptions of this side of the phenomena were rich and varied within the two interviews and to remove them would have been not representative of these midwives' lifeworlds. Another example was concerned with the context of the independent midwives' practice. This aspect of the phenomenon comprised the *intimate knowing of the woman* which was afforded by their caseload model of practice. This example was more complex and took more critical evaluation to make a decision (Giorgi 2009). Whilst at first this aspect of the phenomenon seemed a contingent rather than an essential part of the structure in terms that it was contextual rather than constituent, when it was removed the structure did appear different albeit subtly as the midwives were reliant in their intimate knowing of the woman to enable the process of perceiving their intuition (Giorgi 2009, p.70).

Reed (1987, p. 102) expressed how the aim of formulation of the general structure is:

“to describe the structure is to describe how the elements of a phenomenon function constitutively, how they interrelate to form the unity of the experience”.

The general structure is then made up of constituent parts, or constituents that relate to each other in a comprehensible way. The aim of the general structure is to have the ability to make sense or create a whole of unique variations. This stage I found the most protracted part of the analysis. Towards the end of the formulation of the structure, however, this became playful, dwelling with the constituents and the structure. I received a sense of the interrelatedness of the phenomenon. I noticed how at times elements of the parts, or constituents would overlap. This was exemplified by the different ways the midwives would perceive their intuition. Whilst in the main they would perceive their intuition by one means of sensing, on other occasions they would sense it by a multiplicity of ways. This is exemplified in the findings chapter (section 4.2.2.2.2, p.125). This interrelatedness also occurred in terms of how the individual constituents related to each other. For example the form of intuition they perceived, how it was utilised and confirmed or disconfirmed; and subsequently how it was honed for their future practice To provide transparency and clarity for the reader, a series of diagrams has been created to depict this and is presented in the findings chapter (see section 4.2.4, p. 193-202.)

It is acknowledged personally that it was difficult to know when to cease the formulation of the general structures; however time limits for the study and an intuitive embodied felt sense also informed this judgment. This was coupled with an acknowledgment of Ashworth’s (2000, p.149) notion of “descriptive adequacy”. This is when the researcher ensures they have sufficient examples within the structure to

enable the reader to see evidence of the invariant experiences from the lifeworld. This process I felt was aided by the tables demonstrating the interrelatedness of the constituents (see section 4.2.4, p. 196-205). Visualising the range and complexity of experiences emphasised that the examples were adequate.

This descriptive phenomenological research methodology and methods have provided a rigorous means to provide some clarity to the phenomenon under investigation. Whilst the presentation of the general structure and the constituents in the next chapter examining the findings communicate this to the reader, a further research process involving a composite description and an embodied interpretation was undertaken with the aim of expressing the findings in an accessible and more evocative way which introduces the next two sections.

3.2.12 Composite description

This secondary form of analysis has been described and exemplified by both Todres (2007; 2008) and Wertz et al. (2011b, p. 5882). This method enables texture to be introduced into the findings and has as its rationale to:

“create new understanding of the phenomenon, bringing about a form of understanding that is relationally alive that contributes to improved caring practices” .

A composite description enables the contextual human qualities of the phenomenon to be illuminated (Wertz et al. 2011b). The process involves blending data from a number of interviewees and presenting it as a first person account. Todres (2007) states that this blending must delineate the boundaries of the phenomenon with contexts to reveal the essential themes of the experiences presented. Similar to the

embodied interpretation the use of the first person pronoun within the description is essential. This indicates that the 'I' as typifying the general experience. Utilising this composite method enabled a conveyance of the "wholeness" of the experience from the midwives (Wertz et al. 2011b, p. 5882).

To undertake this method all transcripts, the meaning units and the transformed meaning were re-read and a narrative description was created including some of the context the midwives had included during their interviews such as the vulnerability of their independent status and the importance they placed on the trusting relationship with women and their partners. The composite description also served to provide a level of confidentiality as individual descriptions may have relayed too many revealing details of the midwives' experiences. Further details of this are included prior to the presentation of the composite description in section 4.2.2.6 (p.186).

3.2.13 Embodied interpretation

Once the essential structures and composite description were formed a secondary phase of analysis or embodied interpretation was undertaken. During this phase the researcher transforms the general structures into an evocative and poetic prose (Todres and Galvin 2006). In the course of this stage the researcher is required to re-read the general structure a number of times and search for an empathic meaning in the structures, this has at its central aim:

"that one finds a sense of common humanity in the resonance between us in relation to the phenomena"

(Todres and Galvin 2006, p. 52).

This interpretation should not only address the logic and details of the text, but also depict the bodily feeling of what the experience may be like. This was the most enjoyable and playful stage and whilst all elements of my research journey have been emotional and intuitive within themselves, this stage was the most emotional. This had at its heart for me a true sense of 'getting it right' so the essence of the phenomena can be communicated effectively. During this process after reading the essence a number of times I noticed how I could inwardly feel a response as the essence was read, I took an extended period of time to dwell with both the essence and my own felt sense. I then crafted the embodied interpretation ensuring the meanings of the essence were communicated fully. I inwardly searched for evocative words and phrases. This became resonant of the formulation of the general structure, only this time I was oscillating between the essence and its evocative communication rather than the constituents and the essence.

The search for more evocative phrases is exemplified by the following excerpt from firstly, the general structure:

an intimate knowing or noticing of the woman that includes the reception of subtle cues

And subsequently its embodied interpretation:

We meet, there are sparks, and we bond

I see you through nuanced signals

I searched for more poetic words that would more resonantly convey the meanings of the midwives' lifeworlds. This stage has at its heart transparency as the reader can witness both the general structure (see section 4.2.3, p.189) and its embodied interpretation (see section 4.2.5, p.206) this is presented in chapter four (p120) which presents the findings of the study. The risk of this stage is the possibility of overstating the descriptions. This occurred on first drafts of the interpretation. For example, the first draft included the phrase:

You learn to trust me. I learn to trust you.

This is vital for my survival.

The words *my survival* however appeared to contain a level of hyperbole and so it was subsequently changed to *our connection*.

It is important to acknowledge that there exists a tension in writing phenomenological descriptions; Wertz et al. (2011b, p.5882) describe this dilemma noting that the researcher's role is:

“to convey its findings in a way that is meaningful for others that also meets scientific standards of credibility, dependability, or confirm ability”

It is important to emphasise that both levels of findings are important and are presented to complement each other. The essential structure provides a logical coherence to the phenomenon which is vital for the complex subject of midwifery intuition. It provides an articulation of its essential factors and how they interrelate. Whilst this provides a comprehension of the phenomena, the embodied interpretation lends sensitivity to the midwives' lifeworlds and empathically explicates their experiences in a thoughtful way. My aim is to create what Todres (2002, p. 3) has described as:

“an attempt to present findings in a way that tried to retain the richness and texture of individual experiences while at the same time offering a level of description that applies more generally and typically.”

The methods section has so far presented the details of descriptive phenomenological approach that has been employed as articulated by Todres and Holloway (2004) and founded on Giorgi's research methods (1985). The secondary phase of embodied interpretation of the general structures as created by Todres

and Galvin (2006) and the composite description (Todres 2007; 2008) has also been explained. The final part of the methods section will consider the ethical considerations of the study.

3.2.14 Ethical considerations

The principles of Bournemouth University's (2012) research code of ethical conduct have been adhered to in the design and execution of the study and an ethics committee submission was prepared for Bournemouth University's Research Governance committee (RG2) which included the information sheet, (see appendix one, p.315) consent form (see appendix two, p.318) and the risk assessment (see appendix three, p.320) for external scrutiny. Ethical approval was subsequently granted (see appendix four, p.330). As the independent midwives are self-employed practitioners caring for women in a private capacity, and recruitment for this study was not through the NHS, it was not requisite to seek ethical approval from the National Health Service Ethics Committee (National Research Ethics Service 2009; Department of Health 2010b).

It has been argued that one of the primary concerns for research is justification of the study from an ethical perspective (Walker 2007). This entails ensuring the study does not needlessly duplicate other work or is not of sufficient quality to contribute something useful to existing knowledge. As the phenomenon under inquiry has lacked definition and exploration within the literature and the rigorous descriptive phenomenological process has been comprehensively researched and presented, it is asserted that this concern has been addressed. Other founding principles include beneficence (do positive good) and non-maleficence which includes the adage

“above all do no harm” (Walker 2007, p.39). Three issues which address this are consent, anonymity and confidentiality (Wertz et al. 2011a). These details are presented below.

Written consent was obtained from all seven participants (see appendix two, p. 318) who were fully informed of the study’s aims and methods (see appendix one, p.315). This included explicit instructions to omit or obscure any information which may identify clients and/or their families. This was emphasised as an acknowledgment that independent midwives do not come under the remit of the NHS ethical committee, therefore it is paramount both interviewees and their clients and families are afforded confidentiality. Confidentiality of interview material has been protected by pseudonyms this has included the independent midwives and any clients and/or their families or place names they have mentioned. All transcripts have been stored in a locked filing cabinet and will be destroyed within thirty-six months of the completion of the research. Interview recordings will also be destroyed (Bournemouth University 2012, Data Protection Act 1998). It is proposed that the general structure and subsequent embodied interpretation will be formulated from a number of analysed transcripts, anonymity will therefore be maintained. Explicit permission has been obtained for using direct quotes in the analysis section and in any future published or presented projects. One midwife however wanted to see any of her personal quotes that are to be used specifically in any publication. This will be undertaken and she will be contacted with the exact quotes to be utilised.

One of the most important ethical considerations for the qualitative researcher is to describe the experiences of others in the most faithful way possible (Munhall 1988). I have an obligation to therefore describe and report my findings in the most

authentic way, even if it is contrary to my aims for the study (Streubert and Carpenter 1995). It is anticipated that returning to the participants for coherence will achieve this. All transcripts have been returned to the participants and agreed as a faithful representation of their words and to ensure confidentiality is maintained.

It is suggested that the means of listening to the participants is a means of recognising and respecting their knowledge and experience. This is particularly important as it is acknowledged that due to their independent status the midwives have given their own time. This may also ensure the ethical principle of beneficence is adhered to (Bournemouth University 2012). Redwood and Todres (2006, p.26) call for “ethical imagination” in their dialogue concerning ethics and qualitative research. They assert that as interviewing is a dynamic process that cannot always be predicted where disclosure of life events occur, an ongoing checking procedure is necessary. During the course of the interviews on several occasions interviewees were reminded to not give too much detail of specific incidents that could compromise their own or their clients’ confidentiality to uphold this concern. Despite this during transcription it was noted that some details of experiences could possibly identify individuals, to address this when all scripts were returned for checking by the participants these details were highlighted for the participants and they were assured these details would not be used or anonymised. An example of this is included in appendix four which contains a transcript and details of an occasion when too many possibly identifying features of a client’s history were discussed during an interview (see p. 355).

Any ethical framework for interviewing must commence with the responsibility of the researcher (Smith 1992). This includes giving due consideration to the sensitivity of the material disclosed and the effect on the individual of self-disclosure (Walker

2007). The emergence of supervisory issues within interviews was acknowledged as a possibility and it was proposed that this could have entailed midwives divulging experiences that cause emotional distress. On a number of occasions as the midwives recounted experiences that were very meaningful to them, they visibly became upset and shed tears. On all occasions I stopped the interview and established whether they wanted to continue. On each occasion the participants wanted to continue and did so. They were reminded at the cessation of the interview that they may wish to speak to their Supervisor of Midwives to talk through and reflect on the experience of being interviewed, however none of the midwives chose to pursue this. It was also acknowledged that there was the possibility that interviews could also elucidate areas of unsafe practice. To support participants in this matter I intended to suggest midwives once again seek the support of their Supervisor of Midwives; this was also detailed on the information sheet and discussed prior to interviews commencing (see appendix one, p. 315). This however did not occur during any of the interviews. I also appointed a Supervisor of Midwives in Bournemouth University who was a senior lecture in research to be available for any supervisory issues that may have occurred, however no events ensued that required her assistance.

Coyle and Right (1996) stress that it is ethically questionable for a researcher to be interviewing on potentially sensitive topics without being able to cope with the resultant distress. As a midwife, educationalist and Supervisor of Midwives I consider myself to have advanced communication skills and was able to anticipate immediately if the participant was becoming upset which was aided by the embodied approach to my interviewing (Finlay 2011). I was however fully aware that my role within this research is that of researcher, not practitioner, educationalist or Supervisor of Midwives (Geanellos 1998).

It is also acknowledged that immersion in lived experiences of others may also render the researcher vulnerable (Walker 2007), whilst I felt empathy for the participants if they became upset I did not feel vulnerable and this issue was discussed with my research supervisors.

The risk, health and safety issues of the study were considered and documented within a general risk assessment and a lone interviewing risk assessment and were agreed by the university's internal research approval system (see appendix three, p.320).

Having presented and analysed the ethical considerations of the study and before the introduction of the findings chapter the timescale of the study is presented in the following table (figure 3:2, p.119) to provide context for the reader:

| | |
|--------------------------------|---|
| Timescale of the study | |
| December 2010 | Registration |
| December 2011 | Submission to Bournemouth University's RG2 Ethics Committee |
| December 19 th 2011 | Approval granted |
| January 2012-December 2012 | Recruitment and Data Collection |
| January-May 2013 | Transcribing and commencement of Data Analysis |
| June 2013 | Transfer from MPhil to PhD |
| June 2013 -December 2015 | Completion of Data Analysis |
| December 2015-September 2016 | Writing- up |
| September 2016 | Submission |

Figure 3:2: Time line of research

The methodology and methods of the study have been presented utilising examples to provide context and enable transparency and rigour for the study. This has served to demonstrate an audit trail of maintaining a phenomenological reflexive attitude throughout the study and an upholding of ethical principles. In the next chapter the findings of the study will be presented. This will present a composite description, based on all of the interviewees' experiences, the constituents, general structure and an embodied interpretation.

Chapter 4 Findings

4.1 Introduction to the Findings

This chapter presents the findings of the phenomenon under study entitled: *independent midwives' experiences of utilising intuition within their practice*. Through the process of descriptive phenomenological analysis, constituents, a composite description, an essence and an embodied interpretation have been synthesised. In this chapter, the constituents are presented prior to the composite description and the general structure (or essence). The rationale for this placement order is that the general structure cannot be formulated without demonstrating how its invariant elements “live out in variant possible ways” (Todres and Holloway 2004, p.90). The presentation of the constituents will enable the reader to trace the development and resonance of the individual constituents and how they at times overlap and interrelate. This will further provide transparency of their synthesis into a composite description and general structure. An embodied interpretation of the general structure will then be presented to address the communicative concern of the study.

The formulation of the composite description emerged from a concern to balance both structure and texture within the phenomenological description (Todres 2007). This will afford the reader a ‘living and situated’ context (Todres 2007, p. 50) to enable comprehension of what it is like as an independent midwife to experience intuition and utilise it within their practice. Contextualisation is essential to any qualitative study, especially phenomenology, as its aim is to focus on meanings and

meanings occur within context (Holloway and Brown 2012). To address this concern the composite description will present the integral complexities of care associated with their experiences and utilisation of intuition. This is presented as a reflective story that has been fashioned from the composite description of experiences that emerged from all seven interviewees which serves the ethical concern to provide confidentiality of interviewees. This description and the constituents are then further focused into a high level of generality to form the central phenomena of the study: the essence of the independent midwives' experiences of intuition and its utilisation in practice. This essential description illuminates how the elements of intuition and its utilisation function and how the constituents interrelate to formulate the experience as a united whole. This will be followed by an embodied interpretation to address the communicative concern of the study.

4.2 Introduction to the constituents and the midwives' context of practice

The aim of the constituents is to provide the reader with "descriptive adequacy" or the provision of evidence of the midwives' experiences of intuition and its utilisation within their practice (Ashworth 2000, p.149). This section will briefly introduce the constituents and the unique practice milieu of the independent midwives. The context of the midwives' independent practice will be discussed both within the individual descriptions of the constituents and in greater depth within the composite description. To provide the reader with clarity however, it has already been introduced within the literature review (see section 3.2.1.2, p.110). Whilst this section presented a rationale and context for the purposive sample of independent midwives selected and was evidenced by the associated literature, the next section

is centred on a brief overview of the distinctive model of midwifery practice for the specific midwives interviewed. It is acknowledged however there is resonance within the literature of their model of care. This brief overview is now presented in the next section.

4.2.1 The practice context of the independent midwives

The interviewees' midwifery practice occurs in a unique practice milieu where the midwife has elected to work independently of the NHS. Within their independent practice, the midwives are selected and privately employed by the woman and her family. Essential to this practice is a mutually trusting relationship between the woman, midwife and her family. To ensure this relationship is effective, the midwives tend to choose women they can successfully work with. This relationship is founded on a mutual connection and then developed through the time and continuity independent practice affords. This relationship is pivotal to protect the midwife from the possibility of litigation. The context of the midwives practice does not form a constituent per se as it is not part of the phenomenon. It does however form an essential part of each constituent and will consequentially be discussed within each section.

An introduction to the composition of the constituents will now be presented.

4.2.2 The constituents

The phenomenon under exploration in this research study is independent midwives' experiences of intuition and its utilisation within their midwifery practice. Intuition has

already been identified within the literature review as a form of knowing. With any form of knowing it is requisite to describe and distinguish between either the process of knowing (or how information is perceived) and what is known (or the information that is revealed through this perception). Intuition as a form of knowledge is no exception and the constituents will reflect both these aspects. However to illuminate the phenomenon it is also requisite to describe how the knowing and knowledge is utilised, confirmed or disconfirmed and honed within their practice to fulfil the aims of the study. These thematic details of the constituents will now be presented.

From the phenomenon under study three constituents were found to be eidetically invariant (Giorgi 2009) within the midwives' experiences of intuition and its utilisation, these have been entitled: *kinds of noticing, kinds of utilisation and kinds of confirmation and disconfirmation of knowledge*. In the first constituent, *kinds of noticing*, both the midwives ways of knowing or perception of their intuition and their knowledge or the information their intuition revealed is explored. Two forms of knowledge were illuminated and have been typified as *vague, specific* or *directional noticing*. These types of knowledge were illuminated by a number of different means or ways of knowing and have been typified as sub constituents. These comprised the: *reception of verbal and non-verbal cues, experiencing a bodily or emotionally sensed feeling, reception of an image and experiencing a dream*.

The second constituent, *kinds of utilisation* expresses how or whether the midwives' intuitive knowledge was utilised and how this occurred. This has been typified into the sub constituents: *enacting an intervention or a specific action, the provision of emotional care and increasing vigilance in care*. The third constituent entitled *kinds of confirmation and disconfirmation* described how the intuitive knowledge was

confirmed or disconfirmed and embedded within their lifeworld as an independent midwife. This has been typified into the sub constituents: *confirmation of the nature of intuition and its juxtaposition with scientific, situational and clinical knowledge, confirmation which provided empowerment and supported intuition as an authoritative form of knowledge, confirmation which reflectively honed present and future practice, and disconfirmation which reflectively honed present and future practice*. These constituents will now be described and evidenced with data from the midwives' descriptions commencing with the first constituent, entitled 'kinds of noticing'.

4.2.2.1 Kinds of noticing

This first constituent expresses what the midwives' intuition revealed in terms of knowledge or information and also how it was perceived or known. The term 'kinds of noticing' was utilised as this phrase depicted both the midwives' process intuitive knowing and the content of knowledge it revealed. Noticing has been defined as "to perceive or become aware of" (Oxford English Dictionary 2012). The term: 'kinds' of noticing was utilised as there were a number of different ways the midwives experienced the process of their knowing: through the reception of verbal and non-verbal cues, experiencing a bodily or emotionally sensed feeling, the reception of an abstract or specific image or experiencing a dream. The term 'noticing' was utilised as this encapsulated the connection between the midwife and the woman as their noticing was linked to an intimate knowing or 'noticing' of the woman. The generic term 'kinds of noticing' also depicted not only the sense in which the knowledge was recognised but also the content of the information or knowledge that was received. The midwives' intuitive noticing revealed two kinds of information: firstly, noticing

which provided generalised or vague information and secondly, noticing which provided specific and directional information.

The first part of the constituent 'vague or generalised noticing' will now be presented. This form of noticing was expressed in the data through one of the following means of knowing which have been typified into the following sub constituents:

- **The reception of verbal and non-verbal cues,**
- **Experiencing a bodily or emotionally sensed feeling,**
- **The reception of an abstract or specific image or**
- **Experiencing a dream.**

Specific or directional noticing was similarly expressed in the data through the following means of knowing or perceiving:

- **The reception of verbal and non-verbal cues**
- **Experiencing a bodily or emotionally sensed feeling or**
- **The reception of an abstract or specific image.**

Vague or generalised noticing or knowledge will first be presented and subdivided into the means in which it was experienced or known.

4.2.2.2 Vague or generalised noticing

This first constituent expresses both what the midwives' intuition revealed in terms of knowledge and also how it was perceived or known which was through either the : reception of verbal and non-verbal cues; experiencing a bodily or emotionally sensed feeling; the reception of an image or experiencing a dream. Vague noticing presented itself as something the midwives could not fully describe or define and

was frequently portrayed as noticing something general or not quite right about the woman.

In a number of cases vague noticing was typified as the reception of verbal and non-verbal cues which introduces the first sub constituent. This form of noticing could occur in the absence of empirical evidence. On occasion however, this form of intuitive knowledge would arise juxtaposed to clinical signs and situational knowledge. This sub constituent will now be presented.

4.2.2.2.1 Noticing which provided generalised or vague information through the reception of verbal and non-verbal cues

This sub constituent illustrated how the midwives experienced generalised or vague noticing by the reception of cues in a number of ways. These typified the reception of non-verbal cues in terms of perceiving the general look of the woman, and verbal cues by means of intuiting or noticing the way words were actually expressed. On a number of occasions the midwives could not specifically define that they had received or noticed cues, this only became apparent however when they reflected on the event during the course of the interview. The midwives' context of practice was on some occasions integral to receiving cues as it afforded the midwives a pattern of care which enabled an intimate understanding or knowing of the woman. The reception of cues was experienced occasionally in the constituent vague noticing and only by two midwives; however this was experienced by the majority of the midwives in the subsequent sub constituent specific noticing. In this first sub constituent concerning vague noticing, the reception of cues was expressed in the descriptive data in the form of both non-verbal and verbal cues. For example, non-verbal cues were noticed by Eleanor whose generalised noticing informed her that something was not quite right about the woman in her care. Eleanor described this

as: "...things that we physically pick up on in a woman". In this example Eleanor was describing how she realised despite the absence of clinical signs there was something 'not quite right' with a woman she was caring for antenatally:

"But there was something about her this day and I (pauses) ordinarily would have missed a one off urine and I don't know whether it was just because she looked different in fact I think it's, that's what it was" Eleanor.

When however Eleanor was asked to clarify what she meant by 'physically picking up something' she related to eliciting subtle cues from observing the woman:

"I felt that something wasn't quite right in how she was looking, not necessarily behaviour, it was more of a look... there was just something about the way she looked that was different and I don't recall it being a facial oedema or anything like that but I just felt something wasn't quite right." Eleanor.

It is relevant to note that although this act was described as 'picking up something' when Eleanor consciously reflected on it she realised that it was based on an observation, albeit not explicitly. This was seemingly in the absence of any empirical evidence:

"And I said to her; after the hour we'd been sitting talking, oh can you do that urine test? Because I just feel I need to have that because there was nothing else that was, you know, she hadn't got any headaches, or anything that you classically describe for pre-eclampsia" Eleanor.

Whilst Eleanor's reception of cues was vague initially, it subsequently became more apparent or specific when she started to suspect the woman was suffering from pre-eclampsia. It was also evident that Eleanor's independent context of practice also affected her reception of cues:

"So I think sometimes, you know, when we are seeing women a lot more regularly and having that time, there's things that we physically pick up on a woman" Eleanor.

This intimate knowing of women in her care through the time independent practice afforded enabled the reception of verbal and non-verbal cues:

"I mean I see women and my check-ups like a lot of independent midwives are about an hour we spend sitting and talking so the physical check-up might only take ten or fifteen minutes, but then there's time to just talk about general life and so sometimes it's either something the woman says or something, a way she looks at you or the way she verbalises something." Eleanor.

This demonstrated Eleanor received verbal and non-verbal cues albeit somewhat vaguely described.

On other occasions verbal cues are received which were more specifically described, for example Fiona, who related an occasion when she spoke to a woman in a general conversation about how she was feeling on the telephone, however realised there was something that was not quite right:

"A lot of our conversations are on the phone with women. And sometimes it's not even the words they're saying, you can just hear something. And, I would, say, and somebody would say: oh no, it's fine, I'm ok and I'll think, you're not ok and I need to come and see you." Fiona

When asked to clarify what she had meant by "just hear something" she specifically related to nuances of communication:

"We will pick up on probably tiny little, you would probably call them you know, the intonation in somebody's voice, the way they're saying it, all that kind of stuff." Fiona.

In this example in the absence of any other observation of behaviour as the communication took part during a telephone conversation, it can be considered that the cues received were explicitly verbal.

In these two examples it has been illuminated how the noticing of cues were presented in a range from the non-verbal cues of the observation of a general look to eliciting subtle nuances of the women's communication. With both Fiona and Eleanor noticing of a look was informed by their intimate understanding of the woman, this is despite, in both these described experiences, the apparent absence of clinical signs. Whilst Eleanor, had to reflect to identify this reception of cues, Fiona's verbal cues were instantly recognisable and clearly defined. Both forms of intuitive knowing were vague in terms of a general look or the tone of voice eliciting that something was just not quite right. Whilst these two previous examples evidenced how the midwives' generalised knowing is elicited by vague or specific cues, other incidences occurred where the midwives experienced generalised or vague noticing by experiencing a bodily sensation, or an emotion which forms the next sub constituent.

4.2.2.2 Noticing which provided generalised or vague information through a bodily sensation or an emotion

This sub constituent was experienced by a number of midwives and noticing could be experienced both individually as an emotion or a bodily felt sense or these could be experienced concurrently. On some occasions it would change from one form to another. The most common terminology for the bodily felt sense was 'gut feeling'. This description is related by Eleanor amongst others and the following excerpt illuminates the complexity of defining this form of intuition:

"I've had quite a few women that I've looked after where I've had a feeling, I've never really thought about where it came from and it's like a possible, I don't know physical reaction? I don't know, I think actually there might have been like a nervous

anxiety or something that is sort of generated internally, unlike panic though, or concern, or worry about, either a mother or baby. I've heard it described as a gut feeling, but that is what it is" Eleanor.

An inherent complexity is evidenced by the interrelation of facets of this typology of noticing, Eleanor appears to be firstly, describing a physical sensation, however then mentions an emotional reaction before returning to the physicality of the 'gut feeling'. This may also be that the midwives had never thought about what their intuition consisted of before the interview and were consequently exploring it for the first time.

The knowledge this form of noticing provided for the midwives was vague although this could provide some clarity as time passed. This is exemplified by Dee, whose vague noticing was expressed as a concurrent sense of foreboding both emotionally and later bodily after she has booked a client into her care in early pregnancy and continued caring for her antenatally:

"I then went back and over the next few visits I just got this feeling and I remember... and through the pregnancy that (feeling) kept repeating, and I was aware of it but it didn't have a definite shape , or a definite form" Dee.

It appeared during this example that whilst Dee experienced an emotion: illuminated by her words 'feeling', this however is seemingly generalised in the way that she is unable to describe it other than it being persistent. Towards the end of the woman's pregnancy however, Dee's sense of noticing changed to a bodily sensed feeling of foreboding:

"I had this horrible; all the previous few days, I just had this horrible sort of sick feeling that, you know, things were not right."

In Dee's example initially the emotion she experienced is very vague simply described as a feeling however this progresses to a more specific bodily felt sense of foreboding which was more informative albeit not yielding specific information.

Alternatively for Louisa, noticing was experienced as a specific emotion. It is pertinent to emphasise that this was not just an emotion in itself it was however an emotion that possibly could be considered to reveal knowledge about practice. In this example Louisa was caring for a woman during labour at her home. During the course of the labour Louise described how her emotional noticing presented as a feeling of love in the room.

"I was completely overwhelmed by the, by my own personal experience of love in the room (sighs). It was almost palpable; it felt like the presence of angels, whatever that is." Louisa.

It is notable that Louisa has described this as a specific emotion: love. She described it however as having almost has a tangible or as she expressed a "palpable" format. Ironically, however she utilised the term "angels" which as Louisa acknowledged, she has a lack of comprehension. Whilst it is apparent that Louisa experienced an emotion this has been only partly recognised as 'noticing'. The rationale for this is that shortly after Louisa had experienced this emotion it appeared to herald a sudden worsening in the baby's heartbeat and the baby subsequently died:

"Very shortly after that, I listened to the baby's heartbeat and it was quite bradycardic and I asked the Mum to get out of their pool and we listened again, no heartbeat." Louisa.

Louisa subsequently questioned whether the felt emotion was connected with the baby's sudden demise:

“It struck me afterwards how very strange it was for me to have been quite I haven’t regarded myself as you know, psychically inclined or anything like that. I’m a very practical person, but for me to have for me to have experienced that phenomenon and then for the baby to have died was well odd really (pauses).” Louisa.

It is evident that whilst Louisa did not fully comprehend the emotion she experienced she appears to link it with a diagnosis of a stillbirth. It remains questionable however whether she was moved to auscultate the heartbeat after this occurrence or whether this was a coincidence.

Conversely, on another occasion, Louisa clearly described how her noticing was almost tangible by its physical nature:

“I do sometime get physiological things like if I’m at a birth... like a sort of belly ache almost, or a sense of, well I don’t want to be too crude, but you know (laughs) when you’ve got wind” Louisa.

In this example Louisa referred to how she noticed a bodily experienced feeling that provided the information that something was not quite right about the progress of a woman’s labour.

Similarly, Eleanor described her noticing as a bodily sensed feeling evidenced by her words “inside” and further depicted its organic nature:

“Something that comes from inside, and not a conscious thought it’s not something that you think ooh, you know, or something you are immediately aware of, but it’s just something that maybe grows and sometimes with time as well you get a feeling as to whether something’s going to turn out the way you’re expecting it I suppose or how the woman’s expecting it to turn out.” Eleanor.

Whilst some midwives experienced this form of intuition as being constant both Dee and Eleanor experienced physical and emotionally felt sensations that also appeared organic and changeable: Dee in terms of the feeling becoming more noticeable and changing from a generalised emotion to a more specific bodily felt nausea, Eleanor by way of an increasing bodily sense that becomes a feeling, or emotionally felt. Whilst Louisa's experience described a constant feeling or emotion, love, and she clearly believed it was intuition, it is not clear however that her experience revealed any intuitive knowledge or information about practice. On other occasions the midwives' noticing would be visual rather than bodily or emotionally felt which introduces the next section.

4.2.2.2.3 Noticing which provided generalised or vague information through receiving an abstract or specific image

This sub constituent was described by only two of the midwives albeit on a number of occasions with Polly. The use of the term abstract is used as while the image is specific to the midwife it may not be comprehensible or specific to the reader.

Polly and Catherine were the sole midwives to experience this kind of intuition within the sub constituent vague or generalised noticing. Polly described on a number of occasions the visualisation of an abstract image which she later defined as a 'birth angel'. In this example she was caring for a woman at home during her labour who was utilising a birthing pool for pain relief:

"I looked beside the pool and I saw this huge, I mean it must have been seven, eight, foot tall, shape in a blue hooded cloak so you didn't see a face, couldn't see a face or anything just presence." Polly.

Polly was unsure what to do with this visualisation however noticed that the position in which it appeared was exactly the position where the woman gave birth:

“And, I thought hmm right ok, hello, we carried on then things started to move and then, she was ready to birth the baby and actually where the angel was, was actually where I had to stand to help her birth her baby” Polly.

Polly became used to this image and on another occasion visualised a different coloured ‘angel’:

“And then since then, I have seen, I am aware of this, I call it a birth angel, coming with me when I set out to a journey, to a birth and I've seen, I don't mind the blue angels but I've seen black angels and the only time I saw one of those the baby didn't make it, baby had something wrong with it but just wasn't going to stay basically, so I always see the blue angels rather than the darker ones.” Polly.

Whilst this aspect of the phenomena has been characterised as vague noticing it became evident that the images would proffer some information. Whilst the ‘blue angel’ was initially an image providing no specific information, as Polly became used to this image it heralded a good birth outcome. The black angel however was a form of information heralding a poor outcome.

Similarly, Catherine would visualise aspects of nature which she would consider being predictive of a good birth:

“Birds have a great significance for me and if I see an unusual bird on the way to the birth, that's a good sign that it is going to go well” Catherine.

Catherine would similarly determine other observations of nature as reassuring if she encountered them on her way to the birth:

“I'd be driving to a birth and I'd see an owl fly right in front of the car: you know, really close a lovely barn owl, I remember one night. Another night I was driving out in the forest I can't remember what I saw there may be that wasn't a bird maybe that was a load of deer really close to the car, really beautiful. Really, really beautiful things and I don't know it just reassures me somehow, and I don't know why.” Catherine.

She did however consider on reflection whether this was because she considered birth being connected to nature:

“Maybe it's the connection with nature because birds obviously have their eggs alright and rear most of them and owls obviously do it, I don't make that rational connection but perhaps it is the idea that life goes on there is a life all around us so it can't be that bad can it? Because we do procreate and we do. But it will be unusual birds that I haven't seen, you know a wood pecker.” Catherine.

The examples within this sub constituent are deemed as vague rather than specific noticing as whilst the means of knowing is specific, that is the observation of an image or specific animal, it is not however generally considered as recognisable knowing and the knowledge or 'good sign', or omen, is not specific. On another occasion a dream was experienced, this was an occurrence that again presented a rare side of the phenomenon: Polly being the only midwife to experience this and forms the next sub constituent.

4.2.2.2.4 Noticing which provided generalised or vague information through a dream

Polly was the only midwife to describe a dream. In this sub constituent the dream, whilst including a particular image, was not specific or directional in terms of

providing information for a course of action. This description provided by Polly, occurred whilst she was caring for a woman antenatally, and she experienced a dream about her client's forthcoming twin birth during the course of her pregnancy:

"One night I had a dream, and I dreamt I saw the baby's head being born and the baby wasn't alive: it had meconium around it, anyway so I wasn't quite sure what to do with this information at all." Polly.

In this example Polly visualised a *specific* informational image in her dream about a still born baby, however both her examples did not provide her with a specific or directional way of interpreting or means of acting as evidenced by her uncertainty of knowing what to do which is why it has been presented and typified as a vague form of noticing. It did however proffer information which enabled her to increase her vigilance and this dream was linked with problems that occurred later. These issues will however be further discussed in section 4.2.2.4.3 (p.160) and section 4.2.2.5.3 (p.175).

In this exploration of the first constituent, the sub constituents, vague and generalised noticing has been described. Vague noticing through the reception of cues has been expressed both verbally and non-verbally in varying levels of specificity. This has enabled the knowledge that something is not quite right about the women the midwives were caring for, seemingly in the absence of empirical evidence.

The second sub constituent comprising a bodily or emotionally felt sensation was the most commonly experienced type of vague noticing. This provided the midwives with a bodily and emotionally felt general sense that something was not right, the possibility of an emotional sensed prediction of a fetal demise and a bodily felt sense that provided a vague notion that a woman's labour was not progressing well.

The reception or the experience of an image was one of the rarest expressed sub constituents and was perceived as an 'angelic' presence which provided a prediction that all would be well within a woman's labour, or more rarely, predicted the demise of a baby. A further expression was as a vision of nature which similarly predicted good outcomes for women's births. The final sub constituent, the experiencing of a dream was only experience by Polly predicting the demise of a baby. Whilst these events were only experienced by one or two of the midwives they have been included as they illuminate another side of the phenomenon and imaginatively vary the range of possibilities within the phenomenon (Giorgi 2009).

Some of these examples will all be explored in more depth during discussion in the constituents entitled: 'kinds of utilisation' and 'confirmation' of the noticing. This will help demonstrate the way the constituents interrelate. This will be given further definition by the presentation of a series of diagrams (see figures 4:1-4:8, p.196-205) at the conclusion of the chapter.

Whereas this sub constituent has described knowledge that was vague or generalised, on other occasions or for other midwives knowledge could be both specific and directional. Kinds of specific and directional noticing were expressed within the descriptive data as intuitive information which conveyed a specific image, or directed a definitive set of instructions, or course of action. The following sub constituents explore how this kind of intuitive knowledge was perceived or known. This kind of noticing occurred through reception of cues from the woman, experiencing a general or specific bodily sensation, experiencing a general or specific emotion, and receiving a specific informational or an abstract image. These sub constituents did not however include having a dream.

4.2.2.3 Kinds of specific and directional Noticing

Within this constituent, the midwives' specific and directional noticing was on many occasions underpinned by the context of the midwives practice and their intimate knowledge of women that this affords. On the majority of occasions it would be in the absence of empirical evidence and some occasions even contradicted by clinical signs. This intuitive knowledge would generally although not exclusively occur during labour. The reception of verbal and non-verbal cues is the first sub constituent and specific noticing is experienced in this way by a number of midwives.

4.2.2.3.1 Noticing which provided specific or directional information through the reception of verbal and non- verbal cues

In this sub constituent, similarly to vague noticing, both non-verbal and verbal cues are determined. In some cases whilst it is evident that some kind of cue is being received by the midwife it was not specific enough to be described as verbal or non-verbal. It also appeared to be underpinned by the midwives' intimate understanding of the woman and in some cases situational knowledge.

Specific and directional knowledge is revealed in the following example through the explicit prediction of a woman's post-partum haemorrhage, however the independent midwife, Fiona, is not completely certain what her noticing involved. Fiona's example of specific noticing occurred when she described a clinical case where she just knew that a woman was going to bleed, in this example, she realised that all was not well with the woman she was caring for in her third stage of labour, seemingly in the absence of clinical signs:

"I knew her really well you know, and I knew that she wasn't right, and you could say: oh well she looked a bit pale, but her blood pressure, and pulse and all that were fine. But I know what she normally looks like, and I know how she normally is and that wasn't how she was." Fiona.

It is apparent on this example that Fiona's intimate knowledge of the woman informed her noticing without any empirical evidence to underpin this. Fiona questioned her own intuition in this example, seemingly unaware of its origin:

"I know everything's normal, I'm still drawing up some syntocinon, and I wouldn't normally do that but I will do it in, on occasion, because there's something that's just in my head that's gone: she might bleed or she's going to bleed and you think (laughs) why is that?" Fiona

When Fiona reflected on it further she realised it was some kind of subtle cue she was eliciting but could not explain it exactly:

"I think that there's a big, a lot of things that go around women bleeding are probably so subtle we don't, we can't see them...but actually I think it is probably those little subtle things that we are almost unaware of." Fiona.

She also considered why she knew the woman was going to bleed and questioned whether it was her situational knowledge of the woman:

"Why is that? You know, is it, because I'm putting the labour together and I'm thinking those women are more at risk? Not necessarily actually, sometimes that is, you know, just something as subtle as you can't even put your finger on it." Fiona

It is evident that whilst Fiona could not specifically identify specific cues she was however aware they were present. She expressed that this was due to her intimate knowing of the woman:

"So, I do think that there's, it is that relationship I think that it's difficult to have intuition with women you don't know." Fiona.

It was apparent that Fiona considered her knowledge of the woman was a vital part to her specific noticing and to illustrate this she described a similar case of a woman experiencing a post-partum haemorrhage when her intuition was absent. In this scenario Fiona had opted to work a bank shift at her local NHS hospital and was caring for a woman in labour whom she had previously never met:

“I looked after a low risk woman, first baby, having a water birth and she collapsed in the pool after she’d had the baby. She had a PPH (post-partum haemorrhage) and I would say my intuition wasn’t as good in that circumstance and I think it’s because I didn’t know her” Fiona.

On further reflection Fiona believed that it could also have been down to the foreign hospital environment which she entitled “the system”:

“I look back and think if I’d just listened and I think if I’d been at home I’d picked it up much quicker because I’d have known that woman, and because I’m in a different environment. I think it does I don’t know if you call it shielding or whatever. I just think that the system has a subtle change in how you react with women.” Fiona

It is evident that Fiona considered both the foreign hospital environment and her lack of intuitive knowledge contributory to her not diagnosing the woman’s post-partum haemorrhage earlier. It is also interesting to note her use of the word “listened” suggesting possibly this is part of her intuitive noticing through the reception of cues. Similarly of note is the identification of factors that inhibit her intuition: firstly her lack of intimate knowing of the woman and secondly the unfamiliar environment of the hospital setting.

Catherine similarly connected her intimate connection with the woman, which included a social element, with the enhancement of her specific noticing through the reception of cues in labour:

“I think it's about having things in common with people and even if it's a thing and not a common like. I have clients that are well into horses because I'm not at all into horses but, I'll find myself (looking to see) if there is anything in the newspaper, looking at the horsey articles do you know what I mean? Because I know they will be of interest to my client and they might well have seen it. To find common ground you can relate to each other a bit better then can't you? The more you know each other, the more you've got in common and the more we can read them as well, you know without words in labour”. Catherine.

Catherine is clearly relating to non-verbal cues evidenced by her assertion “without words”, and related to eliciting the woman’s physical and emotional needs. For other midwives this form of noticing would reveal specific knowledge. For example for Eleanor, specific noticing through the reception of behavioural cues enabled her to realise that women’s labour became obstructed before clinical signs manifested:

“There's been a couple of first time Mums that have ended up with obstructed labours and you know again you've got all the text book signs and things but before that even manifests there are behaviours that women elicit” Eleanor.

In one of these examples Eleanor was caring for a woman expecting her first baby at home. The woman’s labour appeared to be progressing well:

“And this labour was stonking along. She was having (contractions or “surges”), the labour was in rhythm and the surges were coming and they were lasting a good minute everything seemed to be going really quite well.” Eleanor.

Eleanor however noticed behavioural cues which led her to believe the woman’s pelvis was ‘congested’:

“And I observed her behaviour when I arrived, she was lying quite flat on her bed and I looked back at the notes and described her as being, looking as if her pelvis was congested.” Eleanor.

Eleanor questioned her noticing and further describes it as both a physical observation and the reception of behavioural cues:

“Now that’s a really bizarre thing to think or say from just looking at a person but I think it was probably from the tension, you know you could see that there was tension there, although on asking her she was absolutely fine and comfortable but I could see that her legs hadn’t got any give to them, they weren’t relaxed and soft and open, like you would expect.” Eleanor.

It is evidential that despite the woman not being aware of the tension Eleanor was acutely aware of this observation even though the labour appeared to be progressing well. This will be further discussed in the constituent entitled ‘*kinds of confirmation*’ (see section 4.2.2.5.3, p.175)

A number of midwives would experience specific noticing through the reception of verbal cues when first meeting a woman when the mutual decision would be made about whether or not to work with individual women and their families. For Polly this provided specific information about whether or not she wanted to work with a woman however she could not clearly define exactly whether this was what the woman said:

“But I mean how much of that is, when you meet somebody, you absolutely know whether they’re your sort of midwife or not, is that intuition? Or is that something you’re picking up from what they’re saying?” Polly.

Polly appears to, in this example, be referring to the reception of cues which other midwives have described as intuitive knowing, it is of note however that Polly considers them to be unrelated to intuition demonstrating the complexity of the phenomenon. Similarly Fiona’s specific noticing informed her that she did not want to work with a woman. In her example the reception of cues was juxtaposed to a

bodily sensed feeling, or gut instinct, however when she reflected upon the event it appeared to be related to the reception of verbal cues:

“And I certainly remember, having a phone call from a woman who was looking for my services and from the telephone conversation, I instantly got a gut instinct that I didn't want to work with her and very interesting because actually why would I make that assumption based on a telephone call? But looking back I don't think there was anything particularly that she said maybe it was just the way that she said it? It's not the words it's how you say it” Fiona.

For Debby she initially described experiencing a 'gut instinct' to describe her intuition on first meeting a client:

“another sort of intuitive feeling is certainly when I first meet a woman ,I have a very strong gut instinct whether they're a good person, no that's not the right word, whether I should be working with them, whether I'm going to have a good relationship with them” Debby.

However on reflection this was considered to be through the reception of behavioural cues evidenced by the use of her word 'reading':

“I'm sure that we're reading a lot of who they are as a person, how they cope with life. I don't know quite you're reading the whole picture again” Debby.

This suggests that Debby would also utilise situational knowledge alongside her intuitive noticing evidenced by her words 'the whole picture'. The majority of midwives discussed intuitive noticing on first meeting a client which could affect whether they would care for them, however for some this decision would be affected by other factors:

“it perhaps ought to change my practice in that I ought to listen to my instinct maybe and walk away from some clients but for whatever I feel unable to do that, you

know, some of that's to do with needing an income and I also believe you know I have this, this misplaced sense that you know that if somebody needs a midwife and they want me to be their midwife you know I want to do that. I don't mind things being challenging. But there's only so much of that you can do" Debby.

This excerpt highlights the complexity of utilising intuition which is juxtaposed on occasions to the midwives' ethical knowing.

The reception of verbal and non-verbal cues has been evidenced to predict a haemorrhage, an obstructed labour and make the decision on whether to care for a woman. It was notable that whilst the noticing has been typified as specific because it predicted something more definite, when compared to the previous constituent vague noticing, it also remains not completely exacting. In Fiona's example whilst she predicted that the woman was going to bleed, she could not explicitly state why. This illustrates that her knowledge was specific but her means of knowing was not completely transparent. Similarly in Eleanor's experience while she noticed the woman's pelvis was congested, she was not completely sure what this meant, this did enable her however to later diagnose an obstructed labour which will be further discussed in the third constituent concerning confirmation of the midwives' intuition. This conversely illuminates that whilst her means of knowing was evident her knowledge was not completely comprehensible. This sub constituent has been immersed in the unique context of independent midwifery which enables an intimate understanding of the woman and also illuminates the vulnerable status of their practice particularly when deciding or not whether to care for individual women. For other midwives, on other occasions, noticing was perceived through an embodied means or the perception of bodily or emotionally felt sensations which introduces the next constituent.

4.2.2.3.2 Noticing which provided specific information through a bodily sensation or an emotion

Common to the midwives' embodied experiences was the specific information that was elicited. This was generally the direction of a specific course of action to be undertaken or prediction of an event, in some cases in the absence of empirical evidence. An intimate understanding of women was also key to some of the midwives' intuited noticing. These embodied responses were experienced by the midwives in varieties of ways. Bodily sensations were as frequently experienced as emotional sensing. Bodily sensations were sometimes felt in a specific and defined area however on other occasions would simply be described as instinctive. Emotional sensing was commonly described as perceiving a feeling. The first part of this sub constituent, bodily felt noticing will now be considered.

4.2.2.3.3 Specific noticing through a bodily felt sense

Bodily felt sensations were perceived by a number of midwives and are evidenced by the following examples. For Polly, a bodily felt sensation was experienced through a definite physical sensation which provided specific directional information. In this example Polly was caring for a woman who had been booked for an elective caesarean section due to her baby lying in an abnormal position and the predicted small size of her baby. However on the woman's admission in hospital Polly detected through an examination of the woman's abdomen that the baby had suddenly grown to meet expected parameters. At this point she informed the couple that the baby remained in an abnormal position however had grown sufficiently to enable the woman to choose a vaginal birth. As she discussed this situation with the woman and her partner, Polly had her hands on the woman's abdomen and the couple discussed whether or not they should go home. The couple then decided

they wanted to go home and were enthusiastic to change their plans for a home birth, however at this point Polly received a 'communication' through her hands which demanded operative delivery at that instant. This was so strong that she felt her hands being 'blasted' off the woman's abdomen:

"You know, they really were up for it...and I got this really strong message through my hands that really nearly shot my hands off her abdomen: No! Caesarean now!"

Polly.

Polly further emphasised the strength of this bodily felt noting:

"Well I actually had my hands, I was palpating the baby at the time it was like a, almost like an electric shock: pushing me off and saying it's got to be, you know section now is all that I got." Polly.

Polly confirmed that the noticing was bodily felt during her reflection on the event:

"The message that came through my hands really not anybody speaking to me it was definitely through my hands-section now." Polly.

Polly's example was the exception as it occurred during a woman's pregnancy.

There were a number of examples when this sub constituent occurred however the most frequent occurrence was when women were in the process of labour. Louisa described an example in which a woman's expulsive phase was taking longer than was anticipated:

"And something in me said she needs to push back against you" Louisa.

Again in this example Louisa related that the noticing was seemingly a bodily felt process by her words 'something in me said'. This noticing informed Louisa that the woman needed assistance to birth her baby. She did however juxtapose this embodied knowing with the possibility of receiving behavioural cues:

"Don't know but it's interesting that it, I was reading her behaviour but sort of something in me said that's what she needs." Louisa.

This demonstrates an interrelation of the constituents however the choice to locate it in the bodily felt sub constituent was the resonance of her words “something in me said”.

On another occasion Louisa experienced a more definitive bodily felt noticing. In this example she is caring for a woman in her expulsive phase of labour and the woman’s progress was slower than she expected. As the baby was being born she experienced a feeling in her throat which informed her that the woman needed to change position to enlarge the diameters of the woman’s pelvis to facilitate the birth of her baby:

“So the baby’s head began to crown and because something in me said something, there was tightness in my throat I could feel, and I said I think your baby might need a bit more room. She was in her bath and it was a big corner bath and I said do you think you can stand up and maybe put one foot on the side of the bath and see if you can bring the baby out like that?” Louisa.

In this example Louisa seemingly had a definitive bodily felt sense of constriction in her throat that appeared to mirror the tightness of the woman’s pelvis and the baby’s passage through the birth canal.

Debby’s knowing was similarly internally experienced as evidenced by her words ‘instinct’ during her care for a woman in her expulsive stage of labour:

“my instinct was to tell her that if baby wasn’t born, I wanted her to stand up. The heart rate had been fine, the progress was ok really, but I had a very strong instinct that I needed her to move.” Debby.

Again in this example, Debby’s knowing is specific and directional. It is of interest that Debby directly acknowledged that this noticing was in the absence of clinical

evidence to the contrary in terms of the woman's progress of labour and the fetal heartbeat.

On other occasions, or for other midwives, specific noticing would be experienced emotionally. The following sub constituent provides the midwives with knowledge or information which is specific and directional in terms of enabling them to elicit the woman's immediate needs in labour. It is also evident that the sub constituents interrelate and there is juxtaposition at times with specific noticing that is bodily felt or through determining cues.

4.2.2.3.4 Specific noticing through an emotional sense

The first example of this sub constituent was described by Louisa who received a specific directional message which provided her with knowledge of the woman's emotional state. Louisa was caring for a woman whose labour became somewhat delayed and she just felt that the woman was holding back from labouring because of a previous bereavement of her stillborn baby:

"My intuition said this woman needs to look the previous birth in the face and say she's going to let go and let the baby out because she is afraid this baby will die too." Louisa.

On this occasion the woman's psychological and physical needs were again, not elicited by empirical knowledge but as Louisa described:

"I just knew that was what needed to happen." Louisa.

Louisa's noticing was specific and directional and this enabled her to empathically sense the woman's needs. Whilst this example typified emotional noticing as sensing the woman's emotional needs rather than experiencing an emotion

personally, on other occasions Louisa would experience a direct emotion or sense of 'anxiety':

"...like if I'm at a birth, I'll in the middle of all the things that are happening and what you're doing and the ridiculous levels of writing that you're doing, sometimes I just think (pauses) does my tummy feel comfortable? And sometimes I don't think that, sometimes it, it doesn't occur to me at all, but what I'm really asking myself is have I got an intuitive sense of anxiety or not? And it's interesting, that when I don't even bother to think about it, it's because I didn't have it. I wasn't worried about anything, so it never occurred to me to think am I worried?" Louisa.

Arguably in this assertion Louisa also mentioned bodily felt noticing evidenced by the use of her word 'tummy' however she clarified this as emotionally experienced in terms of her mentioning the term 'anxiety'. This illuminates the complex nature of intuitive noticing and how it interrelates across the sub constituents.

Debby also experienced emotional noticing which was evidenced by the feeling that she should not leave the geographical area near a woman's home. This occurred when a woman had called her thinking she was in labour however when Debby arrived and discovered on examination she was not:

"She called me out to her, quite early in the morning and when I got there, she wasn't in labour (pauses) but I felt ... (pauses). But I mean she lived a long way away from me so this is all my decision making, but I knew she wasn't in labour (laughs) but she was dilated, she was quite dilated nine (pauses) and I went into the town, the near town and just had a drink and a wander round and I knew not to be far away." Debby.

Debby's emotional noticing was supported by her word 'felt'. This will be further discussed in the constituent '*Kinds of confirmation and disconfirmation*' (see section 4.2.2.5.4, p.181).

Eleanor's experience similarly involved just knowing she needed to stay with a woman. In this example, Eleanor's client had been booked into the hospital for induction of labour due to post maturity. Eleanor, who accompanied the woman, had decided to leave the woman as there had been a delay in her induction due to a busy workload:

"Now ordinarily I would usually go in with women and sit with them just for a little while maybe until they had their first prostin and but this particular day there was a delay so we'd gone in at one o'clock and I'd spoken to the midwives and they weren't going to do anything to at least half past three. So I'd said to the mother, do you know I think I'm going to go back have some lunch and then I'll come back."

Eleanor.

However within ten minutes of making this decision Eleanor emotionally felt a sudden need to stay:

"so they actually put her on the monitor but I had this overwhelming urge that actually I really needed to stay and I don't know whether it was because it was really busy and I felt that. I just had an overwhelming feeling that I needed to be there."

Eleanor.

Eleanor's emotional noticing is evidenced by her words "*overwhelming feeling*". It is also apparent that she made her decision to stay underpinned not only on her emotional noticing but also on the lack of staff on the ward. This will be further discussed in the constituent exploring confirmation of the midwives' intuition (see section 4.2.2.5.2, p. 171).

For Catherine, emotional noticing would predict the onset of a woman's labour, for her this was a frequently occurring event:

“Being on call if you work very closely with your women and eventually you get a feeling that they’re going into labour. Mine’s always preceded by an argument with my husband. I know if I have an argument with Toby within a day or two that client will go into labour. Honest to God, it is so predictable.” Catherine.

Catherine’s emotional noticing appeared to parallel her own personal lived experience she does however question whether this is her own expectations that she needs to release prior to the impending birth:

It’s as, if I don’t know, the expectation and anticipation rise and rise and rise and there just has to be some outlet for it. As I know that someone’s, you know, early due and then perhaps I need that so I can be really calm for the birth perhaps I need to expel all that.” Catherine.

It does however suggest an intimate connection between her and the woman to the point where she experiences insomnia the night before a birth seemingly in the absence of empirical evidence:

“Even if I see them in the day and there’s no sign of anything I find myself not able to switch off, I don’t know like I’m heightened awareness. And it will be literally as I eventually put my head on the pillow at one or two in the morning or whatever it is, the phone will go , I’ve had that so many times” Catherine.

She does however on reflection consider whether it is utilising nuances of the woman’s behaviour and clinical signs:

“But again, I rationalise that, I think I pick up things from the women, they’ll be saying I feel a bit more achy or feel really tearful over the last couple of days or can’t stop cleaning the house or whatever their nesting thing is. I think I pick up on all those little nuances don’t I? The uterus feels nice and soft and the baby’s well down and somewhere in the back of my mind it puts it all together and works out that someone’s going to have their baby.” Catherine.

This demonstrates an interrelation of Catherine's emotional noticing with the previous sub constituent exploring the observation of behavioural cues and a degree of situational knowledge once again demonstrating the complexity of the midwives' intuition.

In this sub constituent the midwives' specific bodily and emotional noticing has revealed directional information to recommend a caesarean section, a change of a birthing position, and the decision to stay with a woman. It has also served to elicit a woman's emotional needs and predict the onset of women's labours. It is evident that bodily felt sensations occurred as frequently as emotions and most noticing occurred in the absence of empirical evidence. It has also highlighted a dimension where noticing can interrelate to other sub constituents, and on this occasion with emotionally and bodily felt noticing. This forms a parallel to the sub constituent vague noticing through bodily and emotional felt noting wherein individual midwives could experience both physical and emotionally felt noticing at the same time. In this sub constituent however, as evidenced by Catherine, emotionally felt noticing could also interrelate with the reception of bodily cues and situational knowledge.

On other occasions specific noticing would occur through the reception of a specific or abstract image which formulates the last sub constituent.

4.2.2.3.5 Noticing which provided specific information through the reception of a specific informational or abstract image

Another representation of the constituent was presented in terms of how the midwives' noticing appeared to provide a specific informational image. This was again only experienced by two midwives: Catherine and Polly. This would provide

direct identifiable information about the baby for one midwife however for another it proffered an abstract image that suggested a course of action.

Receiving a specific informational image is described by Catherine:

I can pick up babies, the sex of babies (laughs) really accurately, so is that intuition that I look at a pregnant woman and get a feeling for whether it's a girl or a boy?

Catherine.

In this example Catherine appears to experience an image that enables her to predict the baby's sex, she also however describes it as an emotion utilising the word 'feeling'.

Conversely Polly described an abstract image that directed her to undertake a set of instructions. Polly was caring for a woman at home during a home birth. In the course of the woman's labour the passage of the baby became obstructed and Polly called for an ambulance. As she tried to release the baby she received a series of abstract images which enabled her to undertake a series of manoeuvres to free the baby safely:

"But in amongst that time this woman, there was white light coming down the middle of her and coming down to me and I felt as if my hands were being guided and then there was magenta, which is often a colour I use and surrounding all of this was this blue light but I really felt that my hands were being guided" Polly.

Polly then experienced a more non-figurative image:

"I could see almost this purple person, it was if we were in a cave and this old person was sitting behind a rock and saying it's alright you do this," Polly.

Polly appeared to be guided through her hands however was also appeared to be hearing instructions relayed to her by an abstract image.

In these two representations presented, Catherine's experience of a specific informational image was perceived emotionally evidenced by her words: "get a feeling" this interrelates to the previous sub constituent. For Polly however, a series of figurative and non-figurative images were experienced which directed a course of action. This description will be further explored in the constituent confirmation.

4.2.2.3.6 Summary of first constituent -kinds of noticing

The various ways in which the midwives noticed has been presented. This has been expressed as: firstly, an intimate knowing or noticing of the woman that includes the reception of subtle cues, own emotions, images and dreams. Secondly, the revelation of knowledge the midwives' intuition would provide. This knowledge was either non-specific or generalised such as noticing something not quite right about a woman; the prediction of an impending stillbirth birth or a safe birth outcome and the proximity of a place of birth. Or specific, such as the prediction of a post-partum haemorrhage or obstructed labour; or eliciting a woman's needs such as physical support or a change of position during labour; or the need for emotional support. This knowledge could also be directional such as the need to stay with a woman either in hospital or within the close locality, the immediate need for a caesarean or guidance during an emergency birth procedure.

This first constituent has expressed the ways the midwives perceive knowledge and the knowledge or directional information this provides. As the phenomenon concerns how this knowledge is used it is necessary to describe how the knowledge is specifically utilised. The midwives' descriptions illuminated the various ways in which the midwives' noticing would be utilised. This forms the next constituent:

kinds of utilisation. This incorporates how the midwife acted after the various forms of intuitive noticing and its concomitant dilemmas.

4.2.2.4 Kinds of utilisation

Kinds of utilisation are typified into the following sub constituents:

- **Undertaking a specific intervention or action;**
- **The provision of emotional care** and
- **Not acting however increasing alertness or vigilance in care provision.**

Within this constituent the midwives would often juxtapose their use of intuitive noticing with other factors. These included the midwives' scientific knowledge, practice constraints, their ethical views or knowing and the woman's and partner's own sense of intuition, knowledge and wishes. The first sub constituent, where utilisation involves undertaking a specific intervention or action is once again deeply engrained with the midwives' intimate knowing of the woman.

4.2.2.4.1 Kinds of utilisation -undertaking a specific intervention or action

A number of the independent midwives undertook a specific intervention and this occurred exclusively following a bodily sensed specific form of noticing. The majority of the examples occurred during labour however the first example illustrated by Polly occurred antenatally when Polly attended a woman in hospital prior to a booked elective caesarean section. This scenario was previously described in the sub constituent, '*specific noticing through a bodily felt sense*' and exemplifies the concomitant ethical dilemmas associated with intuitive knowledge. It also illuminates the intimate understanding Polly has with her clients.

The first example of this sub constituent concerned Polly's previously described specific bodily felt noticing when she received a message through her hands. Polly subsequently acknowledged that this message was clear guidance for the woman's and baby's welfare and suggested that the couple opt for a caesarean birth. She does however still inform the couple they had a choice to have a vaginal birth even if it is against the recommendations of the hospital staff and her own intuition:

"I said this baby's in the right place for a breech and it's the right size if you want to change your mind: you might upset quite a few people here but hey it's you and the baby that are important. But you know I was hugely relieved when they said no, we're going to go for that, for a caesarean." Polly.

What is pertinent to emphasise in this scenario is how Polly will only make a decision based on her own ethical code to support the couple's actions at all times. This is further evidenced by her use of the pronoun 'we' which highlights that decisions are made collectively between her and the prospective parents. This is despite what she considered to be:

'A very clear, definite situation where there was no doubt about what had to be done'. Polly

This illustrated how Polly has no question but to act on her noticing by recommending the intervention of a caesarean section. This description also illuminates the certainty of Polly's intuition. It is also notable that the couple also heed by her decision. She made direct reference to her intimate understanding of the couple:

"I think I actually work a lot that way: when you're working with couples you're very closely linked." Polly.

Conversely, Fiona's utilised her intuitive noticing to avoid working with a woman. This was previously described in the sub constituent '*specific noticing through the reception of cues*' wherein Fiona elicited that she did not want to work with a woman during a phone call to establish booking. During her telephone conversation with the woman, Fiona's noticing provided a very definite response:

"I thought I don't want to look after you in fact so much so I don't even want to meet you which is really strange." Fiona.

Fiona utilised her intuition to decide not book to woman for maternity care and fabricated an excuse to meet these ends:

"And so I rang her back and said it was interesting her baby was due on Christmas day so perfect excuse for why I didn't want to look after her so I said I'm really sorry my husband has put his foot down and said that I'm not going to be on call over Christmas 'cause I've been on call for the last x years." Fiona.

This decision is juxtaposed to the context of her independent status which is further discussed in the constituent entitled '*kinds of confirmation and disconfirmation*' (see section 4.2.2.5 (p. 164).

There were a number of examples when this constituent occurred however the most frequent episode was when women were in the process of labour, similarly to the bodily felt noticing sub constituent. Louisa's experience related such an occasion in her early described noticing when she intuited that a woman needed to push back against her. This occurred when a woman's expulsive phase was becoming somewhat delayed. In this exemplar Louisa directly acted on her intuitive knowledge:

“So I put my hands on her sacrum, crossed my palms on her sacrum (crosses her palms and simulates action) and I said, I'm here, push against me all you need.”

Louisa.

Unlike Polly, Louisa acted without hesitation. This appears to provide new midwifery practice knowledge as this manoeuvre has not been recorded in any maternity literature. Debby similarly acted when she intuited that a woman's position needed to be changed to standing during a woman's expulsive phase. This was previously described in bodily-felt specific noticing when she intuited the woman during her expulsive phase needed to stand up:

“She was a grand multip and she said it was the hardest of her labours and it was very slow, and not what you'd expect for a grand multip I suppose, and although I know that often those labours are a bit odd and as the baby was being born, I think it was happening quite slowly and my instinct was to tell her if the baby wasn't born, I wanted her to stand up.” Debby.

It is clear from this excerpt that Debby was also utilising her situational knowledge. She continued and acted immediately on her intuition by asking the woman to stand acknowledging that this was a direct intervention evidenced by her assertion:

“I acted much quicker than I would normally had done,” Debby.

It is notable that in Debby's example she seemingly acted immediately even though it was against her usual paradigm of practice. In Polly's case however, although the message appeared to carry a sense of urgency she fully consulted with the parents prior to acting.

In this sub constituent the specific interventions have included recommending a caesarean section, supporting the woman's position during labour, changing a

woman's position; and the specific action entailed the decision not to book a woman for maternity care. The independent midwives would seemingly sometimes juxtapose other forms of knowledge with their intuitive noticing. For Polly this was her ethical knowing and intimate connection with the couple, and for Debby, her situational knowledge. On other occasions utilisation would entail the provision of emotional care which formulates the next sub constituent.

4.2.2.4.2 Kinds of utilisation-providing emotional care

There was only one example of the provision of emotional care which was previously described in emotionally sensed specific noticing. It has however been included as it reveals another side of the phenomenon and imaginatively varies the range of possibilities within the midwives' utilisation of their intuition (Giorgi 2009).

In Louisa's previous example of empathetically intuiting a woman's emotional state following bereavement, she acted on her noticing by providing the woman with emotional care. In this exemplar when Louisa noticed that the woman was holding back from labouring because of a previous bereavement she gently suggested that the woman released her fears and embraced her new baby:

"And so with the kindest speech I could, I said I think you know baby will come when baby's ready and the best way to help this baby to come is for you and your husband to be close, and intimate and to cuddle up, but I also think you need to know that this is not the last babyand that this baby needs to know that you will love this baby just as much, but differently, and that it's ok for this baby to come out" Louisa.

It is notable that in this example Louisa provided emotional care sensing the woman is fearful that having suffered the bereavement of her previous lost baby that she

may also lose this one. She subsequently suggested that the woman could confront this in warmth and safety of her husband's embrace. Provision of emotional care has resonated with the first sub constituent, undertaking a specific intervention or action, in regards to the absolute conviction the midwives' possessed about their intuitive noticing enabling them to utilise it directly. On other occasions when their intuition was not so specific however this was not possible which introduces the next sub constituent.

4.2.2.4.3 Not acting however increasing alertness and vigilance in care

On a number of occasions, exclusively when the noticing was vague or incomprehensible, the midwives chose not to act on intuition but would however increase the alertness and vigilance in their care provision. Their acting could also be delayed if the women declined recommendations.

For Polly, this occurred during her earlier described example of having a dream about a stillborn baby. Polly initially questioned why she has experienced the dream:

"Anyway so I wasn't quite sure what to do with this information at all." Polly.

In this experience Polly cared for a woman who had decided to give birth to her twin babies at home. She does however, despite questioning her dream, increase her vigilance in assessing for any problems:

"And just thinking well why on earth did I get that? We checked the babies, everything was all right," Polly.

Subsequently the woman commenced labour and Polly cared for her at home when suddenly the labour was not progressing well and Polly suggested she transferred

to hospital. The woman however declined and subsequently later during the labour, one of her twin baby's heart beats could not be auscultated and the woman consequently agreed to go to hospital. It is significant to note that again Polly's decision making was based on her own ethical code to support the woman's wishes at all times despite what she considers outside influences. This is consistently emphasised by Polly:

"But I still can't force them to. You can only give advice, talk to women about your experience so far, and they have to make the decision" Polly.

This was often at odds with her personal beliefs demonstrating the complex nature of experiencing intuitive dreams and feelings:

"We're not bullying them or harassing them or grinding them down to do what we want, even though we might wish we could on occasion." Polly.

It does also appear to show that on occasions the midwives would prioritise their professional ethical guidance over their intuition which lends further understanding to the midwives' use of their intuition.

Dee similarly did not take any direct action in terms of intervention however increased vigilance in her observations. This occurred in Dee's earlier described example where she experienced a bodily sensed feeling of foreboding which grew during the woman's pregnancy. Despite there being a lack of impending clinical signs or symptoms that there was anything wrong during her pregnancy Dee became increasingly mindful with all her observations during the woman's pregnancy:

"Whenever I saw her you know, I was very vigilant I suppose about looking for things, or, not overly vigilant, but you know, just assessing everything and you know, exploring everything". Dee.

It is notable in both these examples that it was difficult for the midwives to act on something that was not tangible unlike the previous sub constituents where noticing was specific and directional.

For Louisa, increased vigilance was enacted when she felt an emotionally sensed feeling of 'heightened anxiety' during a woman's labour. This feeling enabled her to increase her vigilance in observing the woman and preparing for an emergency:

"so that's quite useful though, because that allows you to think ok so let's be really calm here, let's just assess everyone's wellbeing again, let's just make sure we've got everything checked that should be checked, let's make sure we've got all the emergency kit organised, let's you know get all the bases covered so that's quite useful that sort of heightened anxiety thing." Louisa.

On another occasion, Debby wanted to act however was thwarted due to practice constraints. This is exemplified when she transferred a woman into hospital as the woman had been vomiting and appeared dehydrated in early labour. Once the woman had received intravenous fluids she was deemed well by the hospital staff who were happy to discharge her home. Debby however wished her to remain in hospital and continued to auscultate the fetal heart:

"But I kept listening because I needed to be reassured and I know as a midwife that at two centimetres a woman is very often on her own at home and nobody's listening in. And it could have been perfectly reasonable to send a woman home at that stage and nobody would be listening but given the whole picture my instinct, my intuition was that I needed to hear." Debby.

It is noteworthy that Debby juxtaposed her intuition with her scientific clinical situational knowledge evidenced by her words 'given the whole picture'. Having

listened to the fetal heart Debby wanted the baby's wellbeing confirmed by continuous fetal monitoring, the hospital staff however would not listen despite Debby attempt at being assertive. In this example Debby was thwarted to act through a lack of monitors at the hospital, and hospital staff not listening. Debby reflected the irony of this situation that despite being in what should be considered a safe environment her intuition strongly informed her there was something wrong with the baby's heart:

"And so this time you know completely a converse I'm in a hospital, I couldn't be in a safer space, but I wasn't sure, and I wanted to pursue that." Debby.

Debby's experience again reflected the complexities that surround the independent midwives' intuition in terms of being thwarted to act on their intuitive knowledge and utilising other forms of knowledge to underpin their actions.

4.2.2.4.4 Summary of second constituent-kinds of utilisation

In this constituent the complexities of enacting a specific intervention have been explored. Utilisation has been expressed as an intervention to recommend the need for a caesarean section or a specific action such as the provision of bereavement support; providing the woman with physical support during labour; or changing a woman's position during birth. It could also be used to make a decision on whether or not to care for a woman. When not directly utilised it was indirectly used to increase alertness and vigilance in a woman's care by increasing assessment of the woman's and baby's condition; or the timely preparation of emergency equipment.

At times this sub constituent has been presented as being straightforward which occurred when the midwives immediately acted on their intuition: generally during women's' labours where professional decisions to act have to be committed to in a timely fashion. On other occasions however the midwives are faced with more

multifaceted situations and are affected either by their own ethical code or knowing, the women's wishes or practice constraints. This seems even more challenging when often the midwives' intuition was subsequently confirmed as being correct. This introduces the next constituent which details kinds of confirmation of the midwives' intuition. It should be noted however that on some occasions their noticing would be disconfirmed. The following constituent includes how the independent midwives' experiences confirmed or disconfirmed the validity of their intuitive noticing and the consequences that were involved in acting or not acting on their intuition.

4.2.2.5 Kinds of confirmation and disconfirmation

In this constituent the midwives described a range of experiences where their noticing was borne out as either correct or occasionally incorrect. Confirmation occurred across both specific and vague noticing. These events would frequently trigger reflection from the midwives. This reflection demonstrated that the independent midwives' intuition was underpinned by previous practice occasions and was developed and reflectively honed throughout their careers, both in the public and independent sector. This constituent is further divided into the following sub constituents:

- **Confirmation of the nature of intuition and its juxtaposition with scientific, situational and clinical knowledge**
- **Confirmation which reflectively honed present and future practice**
- **Confirmation which provided empowerment and supported intuition as an authoritative form of knowledge and**
- **Disconfirmation which reflectively honed present and future practice.**

It is however acknowledged that whilst these divisions have been made, this constituent appeared to have the most interrelation between the sub constituents. This essentially occurred in the first three sub constituents concerning confirmation, that is all three confirmation sub types had elements of one another but with a differing emphasis. This degree of interrelation will be presented within each sub constituent and serves to demonstrate the complexity of the phenomenon. The first sub constituent will now be discussed.

4.2.2.5.1 Confirmation of the nature of intuition and its juxtaposition with scientific, situational and clinical knowledge

Confirmation would have a great impact on the midwives, this included reflection upon how they utilised their intuition. This type of confirmation incorporated the range of both specific and vague noticing. It was also exclusively concerned with confirmation of the midwives' utilisation in terms of undertaking a direct intervention or specific action. This sub constituent highlighted the complexities of utilising intuition. A number of experiences are utilised to illustrate this sub constituent as they identify the opposing views and experience of the midwives which has also served to imaginatively vary the range of possibilities (Giorgi 2009). For Polly and Debby intuitive knowledge was a tool to be utilised alongside their scientific, clinical and situational knowledge, for Louisa however intuitive knowledge was prized above her scientific knowledge. A number of midwives also utilised their scientific knowledge reflectively to confirm their intuition was right after the event. These descriptions will now be presented.

In Polly's previously described example of bodily felt knowing through her hands, which demanded 'caesarean now!'; the couple she was caring for subsequently

decided to opt for a caesarean birth and she later attended the woman in theatre where she started to question her own decision making:

“Anyway baby came out, beautifully born and I was thinking well why do we need this section? Why did we get this clear message?” Polly.

Following the caesarean section however, it is subsequently discovered that the placenta had a part of it missing which could have severely compromised the baby’s welfare during labour:

“We went and looked at the placenta and it all looked normal on the top membranes fine and we turned it over and where the cord insertion was there was a cotyledon missing.” Polly.

Confirmation in this scenario evidenced that Polly’s intuitive knowledge was correct. She did however state that she constantly tried to balance her intuitive knowledge with her scientific knowledge:

“I’m constantly trying to balance the scientific with working that way because no matter what is said about us we’re very aware of what is absolutely normal: I think because you get steeped when we’re working with women, we’re steeped in normal .You know very quickly when something’s gone off the normal path” Polly.

Whilst Polly stated this, she did however appear, in her previously described scenario, to balance the parents’ views rather than her scientific knowledge or her experiential knowledge of normal childbirth. This could have however been implicit within her bodily felt specific noticing and not evidenced in her interview. What is evident however is that she utilised her scientific knowledge to confirm that her intuition was correct through the placental examination.

Debby similarly utilised her situational and scientific knowledge alongside her intuitive knowledge. Debby's example concerns her earlier described practice experience of encouraging the woman to stand up during her expulsive stage. Her noticing was confirmed when it enabled the woman's birth to be expedited. Debby utilises her clinical situational knowledge of the woman alongside her intuitive knowledge:

"it wasn't a particularly long labour at all, or a long birth, but I suppose it was that I knew the baby was big, I knew she was overdue so again this clinical stuff going on in the background; But you know the heart rate had been fine, the progress was ok really but, but I had a very strong instinct that I needed her to move and yeah and she yeah that's right and she stood up and the baby was born but the baby was completely tangled in the cord." Debby.

It is evident that whilst empirical evidence was normal in terms of the heartbeat and the progress, Debby was also aware of an overall risk assessment of the woman's gestation, the size of the baby and her overriding bodily felt intuition. In this example, it was again clear that Debby's actions not only expedited the birth but may have prevented the baby from becoming distressed had the birth taken longer due to the position of the cord. This confirmed her action was correct which was important to Debby as she intervened sooner than she normally would have done and the baby needed resuscitation:

"She did need a little bit of resuscitation and, and I did call an ambulance so my instinct was absolutely right, to do something and that was that I acted much quicker than I would normally had done, and I don't quite know why I did but I guess you know as I've said to you there were several clinical things." Debby.

On another previously described example, when Debby would not leave the geographical area surrounding a woman's house, she received confirmation of her emotional felt noticing:

"And, but again it's clinical skills because she was quite dilated, she wasn't in labour, but she rang me and I wasn't far away at all and I got back and the baby was literally coming so, you know my instinct not to go far away was strong and right year so, but again clinical skills in there as well, but she wasn't in labour when I left her" Debby.

In this example Debby was clearly right to stay in the locality as the woman subsequently gave birth rapidly however as she acknowledges her intuitive noticing was juxtaposed to her clinical knowledge which aided the utilisation of her intuition and subsequent decision making.

Louisa again received confirmation in her earlier described experience which involved her action of supporting the woman's sacrum and encouraging her to push against her. This had a dramatic conclusion as evidenced by her actions which expedited the birth of the woman's baby:

"And she did, and if I hadn't my elbows locked I would have been crushed, by the power of her. And then her waters released and the baby was born less than a minute later, just went phh fell out" Louisa.

It is pertinent that her actions enabled the woman to expedite the birth of her baby during a long, tiring expulsive phase of labour. Louisa balanced her intuition with scientific knowledge in her following reflection which considered the possible physiological causes of why this occurred:

"She just needed that, I don't know why though the baby, I think the baby was deflexed, I think it came down deflexed, and when we examined it, the baby had a

really small anterior fontanelle and I wondered whether it was hard for that baby to mould its head.” Louisa.

This occurred post event, evidencing that she reflectively utilised her scientific knowledge to aid understanding and confirmation of her intuition. On another occasion, however Louisa demonstrated a clear separation between her intuition and her scientific knowledge which she described as two different voices:

“Because the rational one wants proof, evidence, measurement, comparison with previous experiences, reference to books, reference to references and the intuitive one is experiential, it just is, it's not requiring anything it doesn't need proof, it's just saying: this is it, this is how it is. It's much quieter, it's a much quieter voice and I think probably there have been occasions when I've ignored it.” Louisa.

One such occasion is exemplified by Louisa when she was caring for a woman who experienced a physiological third stage that was somewhat delayed. Louisa had considered administering an oxytocic drug to expedite the delivery of the placenta. At this juncture however, Louisa became aware of her rational voice which demanded an oxytocic drug to be given and how her intuitive bodily felt noticing conversely asserted a different course of action:

“And so she sat on the loo and I was running the bath hoping that the running flow of the water would help her and something in me said don't give her that injection, don't give her that injection, don't give her that injection. But my rational side said come on because otherwise you're going to go to the hospital” Louisa.

Subsequently, Louisa administered the injection, however at this point the placenta was born in the toilet. When it was subsequently removed, it was a small placenta with a velamentous insertion. Consequently Louisa realised that if she had pulled, the cord would have snapped with dire circumstances and she questioned her rational knowledge:

“But it had a complete velamentous insertion, if I had pulled, I’d have left it inside her, because it would have, the cord would have come off. It’s interesting that my rational self was all in favour of active management ...but my intuitive side said don’t pull, don’t pull, don’t pull, don’t pull” Louisa

This confirmation of her intuition assisted her in further trusting her intuitive voice over her scientific or rational knowledge:

“So it’s quite interesting so that sometimes, I think probably it’s my scientific background there’s often that inner dialogue between the rationalist, that says you don’t have enough evidence for that and the intuitive side which says Nerr, that’s what I think.” Louisa.

In this sub constituent, all cases of confirmation have been concerned with bodily felt noticing. Confirmation not only evidenced that their intuition was correct; it further delineated how the midwives juxtaposed their scientific and situational knowledge with their intuitive knowledge and further utilised it reflectively to enable comprehension and confirmation of their intuition. For Polly and Debby this was their constant modus operandi, for Louisa however whilst she clearly reflected on her scientific knowledge to aid her comprehension of her intuition; confirmation occurred for her intuition rather than her scientific knowledge in one scenario. Confirmation of intuition also interrelates to the following sub constituent however in terms of how it aided the authority of the midwives intuition.

4.2.2.5.2 Confirmation which provided empowerment and supported intuition as an authoritative form of knowledge

This sub constituent tended to occur in a number of cases where confirmation provided the recognition that the midwives’ intuition and its utilisation was correct.

Concurrently, this led to personal empowerment as well as further trust being assigned to their intuition. Again, confirmation was exclusively linked to enacting a specific action or intervention. It is acknowledge that this interrelates to the previous sub constituent in terms of the recognition that it was correct, however in this form of confirmation the empowerment the midwives received and the authority this enabled them to place on their intuition was more explicit.

Fiona exemplified this sub constituent when she received confirmation on the occasion she chose not to book a client for maternity care. This example was previously described in the sub constituents '*specific noticing through the reception of cues*' and '*kinds of utilisation-undertaking a specific intervention or action*'. Fiona's confirmation occurred when the woman booked another independent midwife and their relationship subsequently broke down:

"So that was fine and she contacted a colleague of mine who went and met her who booked her and then de-booked her after a month because she felt that the woman was not interested in listening to what she had to say. She just sort of wanted her as kind of a backup for the NHS but was still going to see the NHS midwife and it was all very muddily and strange." Fiona.

Whilst Fiona does not completely comprehend what happened, for her this resulted in the realisation that her intuition was correct set against the context of her independent practice:

"I did think to myself actually I made the right decision if that make sense and certainly I suppose because so much of what I do is based on good relationships because we are very vulnerable to being sued and being reported to the NMC. That is really important to me so I feel that you will pick up a lot of stuff from women and so I'm not saying I'm defensive because that's not the case but I have to protect myself because I've seen too many of my colleagues end up in really awful

situations so I think to myself well actually I don't want to put myself in that position so I'm quite wary." Fiona.

From this statement it is evident that the unique context of independent practice necessitates good relationships between the midwife and her clients and the importance this places of her intuitive noticing.

Eleanor received confirmation following her previously direct action of staying with her client during her induction in hospital. This was following her intuitive emotional noticing. The woman had just been placed on a cardiotocograph and the midwife had left her bedside, at this point Eleanor received confirmation of her noticing as the monitor demonstrated an unreassuring fetal heart tracing:

"She went on the monitor and within literally minutes of her being on the monitor big deceleration down to about eighty beats a minute ...but then she had another one which was a late and then she had another one. So in the space of ten minutes she'd had these three quite deep decelerations and although they came back with good recovery and everything, they were unprovoked and we tried to turn her position, and actually what was interesting as well, because the ward was busy the midwife put the woman on the monitor and walked away" Eleanor.

Eleanor was able to directly act in the absence of the midwife by changing the woman's position to enable increased placental perfusion, she then called the midwife and after a further deceleration and examination the decision was made to undertake an emergency caesarean section:

"And luckily I was there because it was me that alerted the midwife. Hey hold on a minute you know so ended up scooting down to labour ward and then she had a prolonged bradycardia and they decided after a vaginal examination, the cervix wasn't dilated at all, (and the decision was made) to go for an emergency caesarean and the baby came out with Apgars, well I think it was one. I think it

gasped, but didn't breathe and then ended up having five inflation breaths and then came round quite quickly." Eleanor.

The condition of the baby was poor at birth indicating that Eleanor may well have saved the baby's life by her decision to stay and her subsequent actions. Eleanor's confirmation enabled her to have belief that her emotional intuition to stay helped the situation:

"I just had this real need to stay and I think if I hadn't have done the first deceleration may have been missed. Maybe the second one because the ward was really busy and the midwife went away, and had I not been there and called her back it could have easily been missed. I'm not saying I'm a saviour or anything like that but it was just the fact that something made me think, no don't leave this woman, she, she needs you here sort of thing." Eleanor.

She does however juxtapose her intuition with her experiential knowledge in the NHS:

"I've worked as a senior midwife on labour ward, I've been very aware of things, practices of especially of putting women on cardiotocographs. To me there's no point leaving the room, you're supposed to be watching you know what's going on with the fetal hearts I suppose it's just more of a bearing on, on practice again as to I don't know, whether you'd leave the room or not" Eleanor.

This interrelates with the previous sub constituent as she had juxtaposed her intuition with her experiential, or professional historical knowledge demonstrating the sub constituents' intimate connections.

For Louisa, confirmation occurred following her previously described emotional felt noticing when her feeling of love predicted the sudden demise of the woman's baby.

This had a profound effect on Louisa which further empowered her to believe she was called to care for women experiencing bereavement:

“It felt like an intuition that I was being called to care for people around loss. Childbirth loss of one sort or another, and that's quite scary, but also (sighs) made sense because, as my own philosophy, faith if you will, that things happen the way they're supposed to” Louisa.

Louisa was not completely sure however whether this was an intuitive sense of calling or a process of rationale deduction:

“I did feel after the first experience, and again I think it was an intuitive feeling, or it may have been (sighs) a rationalisation of a number of emotions, I don't really know” Louisa.

This calling also appeared to be confirmed:

“And it did seem that way because during the last year, following the first couple's loss I've had a dis-proportionate number of opportunities to work with people who had experienced loss” Louisa.

Although this experience could not conclusively reveal whether Louisa's emotional noticing revealed practice knowledge, it clearly had a profound effect on empowering her lifeworld as a midwife.

Debby received confirmation of her intuition in a previously described experience. This was the occasion when she wanted a woman's baby to be electronically monitored and consequently when the hospital eventually had the facilities and staff to electronically monitor the heart beat, the cardiotocograph tracing indicated the baby was distressed:

“And then when, when the baby was monitored the next morning the trace wasn't good” Debby.

Debby does however acknowledge the questionable nature of this validation:

“It may well have been fine the night before but we don't know and there was a very long time lapse and when it was put on it wasn't good.” Debby.

On subsequent reflection she acknowledged how her intuition was correct and her main area of learning was to trust her intuition in the future and to be more assertive with other health practitioners:

“So I suppose I feel a slight regret that I didn't fight harder, as I'm saying that I wasn't more assertive, but I also feel empowered and I will learn I will, I'm sure I will carry that forward into other experiences to trust my instincts. Because I was correct I believe.” Debby.

This sub constituent demonstrates the complex nature of intuition and its juxtaposition with other factors, in Fiona's case confirmation was intertwined with her independent status, Eleanor with her experiential knowledge, Louisa with her rational thought and Debby with practice constraints. It is apparent that Debby's intuition affected her emotions in terms of her use of the word 'empowerment', however all midwives included within this sub constituent exhibited the authority that confirmation have afforded their intuitive practice. It was also evident that throughout the process of the interview that her reflection was still developing as she was enabled the time and space to contemplate this. This is interrelated to the next sub constituent concerning reflection.

4.2.2.5.3 Confirmation which reflectively honed present and future practice

This sub constituent explores how confirmation of the knowledge had a profound effect on the midwives in terms of reflecting on and consequently developing their

present and future practice. This in part concerned the occurrences when midwives did not choose to act on their intuitive knowledge and their intuition was subsequently confirmed in prophesying poor outcomes. It does however also include other more positive experiences which enabled the midwives following reflection to establish that their intuition had enabled the development of what could be considered to be 'new' knowledge.

Polly, for example, had confirmation of the dream relating to the stillborn baby she experienced. In this earlier described example, Polly unsuccessfully tried to encourage the woman, pregnant with twins, to transfer to hospital when her labour was not progressing well; however the woman eventually consents when one of the twins' fetal heart is unable to be auscultated. On arrival to hospital the woman consents to a caesarean section where Polly's prophetic dream becomes realised:

"The awful thing was that the first one was dead and the second one was alive and what had happened was absolutely what happened in my dream" Polly.

Polly is understandably deeply affected by this experience and questions the value of her intuition:

"So that was really a really a very marked situation and I think I question what was the point of me having that dream and I didn't follow, I didn't know how it could have changed what we were doing. Apart from we could have bullied and harassed her in to hospital." Polly.

She also considered whether she could have done anything differently:

"So, I mean that did I think the only thing that I learnt from that was to be perhaps stronger about things" Polly.

She subsequently reflected however that she has always presented parents with her clinical judgement and risk assessment:

"I try to find the right balance when women are carrying breech or twins and say to them well if the labour stops or falters and it's not a good, well progressing labour that nature's trying to tell us something and that we need to take notice of that and go in and say hello, you know because we have safe surgery in this country that's not usually not very far away, why step over that extra risk fence if you like?" Polly.

She does however conclude that her practice centres on providing care where women are the prime decision makers in their care:

"But I still can't force them to. You can only give advice, talk to women about your experience so far, and they have to make the decision" Polly.

This is despite the poignant consequences of this:

"and I know that she still lives with that, as much as I still live with that neither of us, no matter how many more babies she has, she hasn't got that first little twin that died" Polly.

This experience enabled Polly to reflect on her practice and confirm it as she realises that however strong and prophetic the dream was, she could not solely underpin a judgement on this and the women's decision making was respected.

Similarly in Dee's earlier described example when she experienced a feeling of foreboding, the baby subsequently died in early labour before she has even arrived at the parents' home. This is despite her coming earlier than the parents requested:

"Then she sort of went into labour and very early labour to start with ...when they did call me, well actually I don't think actually did say come now but I decided I'd go now." Dee.

Dee was unable to auscultate the heartbeat on her arrival and the baby was stillborn:

“And when I arrived I couldn't find it ...and yeah so when the baby was actually born, it was stillborn.” Dee.

For Dee reflection encompassed the realisation that her intuition was correct:

“But that you know, all the, way just from the beginning of meeting her, throughout points in the pregnancy I just and I'd actually voiced them to other people, so it wasn't something that I'd made up in retrospect it was something that was real at the time yeah?” Dee.

She had also learnt from this event the different forms her intuitive knowledge took:

“Sometimes when I've met people in the past, maybe there's certain things about them that I just feel a bit uneasy about but it's more about perhaps connecting, emotional connecting rather than a gut feeling that that something fundamentally is wrong or will be wrong you know.” Dee.

From this event Dee could determine the difference from a relational connection to a bodily sensed feeling of foreboding.

In both these examples confirmation occurred with dire consequences, for Polly this enabled her to examine her practice however conclude that her future practice would remain the same, for Dee the enormity of the event enabled her to confirm and hone her use of intuitive knowledge by recognising its differences. The serious nature of the ramifications of the midwives actions or inactions caused the midwives to reflect and hone or at least accept their paradigm of practice.

On other less severe cases confirmation reflectively honed present and future practice. For Eleanor her vague noticing was confirmed when she undertook a urine test following the reception of non-verbal cues that the woman did not look quite right and she discovered the woman had severe proteinuria and pre-eclampsia:

“And I said to her; after the hour we'd been sitting talking, oh can you do that urine test? And she had four plusses of protein” Eleanor.

This confirmed for Eleanor the accuracy of her intuitive noticing. This confirmation enabled her to make the decision to refer the woman to a consultant and subsequently the woman was safely cared for and had a caesarean section:

“I'd sent off a sample and what have you but we ended up seeing a consultant and the baby actually was delivered within the week or within a week to ten days after that event.” Eleanor.

The experience of having her intuition confirmed as correct further enabled Eleanor to reflectively hone her practice:

“Certainly since that particular case, it did make me more aware that we don't always have all of the information to hand and I think it has a bearing on your practice and how you work that you know something” Eleanor.

Whilst Eleanor had not any future cases of serious pre-eclampsia to embed her learning she believed the experience had honed her practice by enabling her to think more laterally:

“Since then I haven't really had anybody that I've had such a significant and fulminating pre-eclampsia with so it's interesting that it was just a sort of seemed to be a one off you know. I've had lots of one offs of things. But I think you learn a lot from those experiences anyway and it makes you think outside the box a bit as well.” Eleanor.

Eleanor similarly had confirmation in her previously described specific noticing through the reception of cues. In the following description this culminated in Eleanor creating 'new' midwifery knowledge in terms of a form of diagnostic tool for detecting a woman's obstructed labour. This subsequent example will elaborate on how this occurred. In this description Eleanor noticed what she described as 'pelvic

congestion' in a woman. In this example she subsequently transferred her to hospital where the woman was diagnosed with an obstructed labour:

"And actually she had a Bandl's ring and what was really interesting about that, I transferred her way before all that. I hadn't had any signs of haematuria or anything like that. But the fact that she was stonking along and labour wasn't progressing and again I suppose that's one of the things you do think about because they are, you know, the signs." Eleanor.

Eleanor's initial noticing was clearly in the absence of other clinical signs or evidence and may well have saved the woman's and baby's lives. The woman's baby was subsequently safely delivered by caesarean section:

"It's interesting because I've reflected a lot on that birth; it had a good outcome she did end up with having a caesarean section" Eleanor.

This also happened on a further occasion:

"But that was another incidence of a first time Mum again having this sort of, I can only describe it as pelvic congestion where they're just not relaxing in the pelvis, pelvic area and I wonder if that's you know, one of the signs of not progressing in labour" Eleanor.

'Pelvic congestion' is not however a recognised clinical symptom and on this second observation on a subsequent occasion, the woman also had an obstructed labour that resulted in an emergency caesarean section. This indicates that Eleanor's observation or noticing through cues created a new form of knowledge that was diagnostic of a pre-cursor to an obstructed labour. She would recognise new knowledge that she would intuitively notice in practice and differentiated it from her academic knowledge:

"You have your standard information that you glean as a student midwife and as a midwife through your career, and then all of a sudden something pops up like that"

feeling and you think right OK this is something I need to remember because it might come up again another time and it might be a skill you can utilise for another event” Eleanor.

From this event and other’s Eleanor would learn from her intuition and situational knowledge and formally record them for future learning and reflection:

“I always write down when something like that happens in the woman's notes, so I can reflect back on something like that if they ended up with a different not a vaginal birth or a vaginal birth with forceps, ventouse or whatever. So, because it's quite useful to just sort of learn more from that particular case.” Eleanor.

It has been illustrated through this constituent how confirmation and reflection could affect the midwives practice in a number of ways. For Polly both her intuition and her ethical means of practicing were confirmed, whilst for Dee and Eleanor confirmation enabled an acceptance and discovery of their intuition which they could then further utilise in their future practice.

For other midwives however, their noticing was disconfirmed. Similarly, this however enabled them to learn more about their intuition and their practice.

4.2.2.5.4 Kinds of disconfirmation which reflectively honed present and future practice

This sub constituent was an infrequent occurrence and was only described on one occasion by three of the midwives. This occurred for Debby and Eleanor whose intuition was disconfirmed which subsequently enabled them to reflect and hone their practice. For Dee however, disconfirmation occurred when her intuition was absent. Key to this was a lack of previous practice experience.

Debby's experience of disconfirmation occurred in a previously described experience when she felt impelled to visit a woman:

"I was caring for a primip who had a breech baby on board who was planning a home birth. And I remember I woke up one morning and I just felt I've got to go: she lived quite some distance from me. And I just thought I've got to go. This was very early in the morning and I just got up and drove to her house and sat outside until it felt like a reasonable time that I could knock on the door." (laughs) Debby.

When Debby however eventually saw the woman her intuition was disconfirmed:

"And the baby was fine and, and in fact she didn't labour she ended up having a caesarean, a bit, probably a few days later" Debby.

Debby subsequently justified this as a lack of experience as it was earlier on in her career:

"And I think I was certainly less experienced than I am now, and I had much less experience of breech birth so I just felt uneasy" Debby.

Debby however learned from this experience of disconfirmation, and other experiences, specific learning in terms of the skill and confidence of not acting immediately:

"All my experiences add up to me having more confidence often, often it's not to act it's often to wait longer before acting." Debby.

For Eleanor her intuitive disconfirmation occurred when she wrongly intuited a woman was in labour:

"And so what was different in that case there was a time I remember thinking ok we're definitely in labour here with mine own intuition which was actually wrong because she stopped labouring (laughs): and went off completely and I couldn't get my head quite round that one because she appeared to be behaving like a woman"

who was in established labour but actually she felt she wasn't in labour which was interesting, because she was right she wasn't in labour and so I was wrong."
Eleanor.

This enabled Eleanor to realise her knowledge was not absolute:

"Which grounded me because I think it's good to have grounding because you're not always right are you as a person?"

It is also noteworthy that Eleanor's specific intuitive noticing involved eliciting her diagnosis of labour from noticing behavioural cues in terms of her word "behaving".

For most of the midwives the separation of intuition and practice was a complex one as they often experienced it as interwoven or at least difficult to separate. For Dee, however her experience of intuition is inseparable from practice as she emphatically stated:

"But you can't have instincts around something that you're unfamiliar with so if you're doing something for the first time, it's difficult to be instinctive about that isn't it or intuitive about something. So you do need to have a reasonable handle of or experience of something, in order to be instinctive I think. So I think possibly those two words could be very sort of interwoven and interlinked, experience equals instinct." Dee.

Dee evidenced this view in an experience when she was caring for a woman during labour who was having a breech birth. Dee had no previous experiences caring for women with breech babies in labour and acknowledged the absence of her intuition and reliance on theory:

"And I was just recounting in my head, I was recounting Jane Evan's breech talks that I'd been to on a number of occasions, and I'd furnished myself with one to ones with Jane prior to that in the hope that it would be more of a theoretical knowledge

to pull on I guess, but I really didn't, I didn't have, I felt very lost at a loss for instincts." Dee.

In this description Dee recounts that her intuition or 'instinct' was absent due presumably to a lack of experience in breech births, and so her theoretical knowledge gained from a study day and one to one tuition was prioritised in the absence of other forms of knowledge.

4.2.2.5.5 Summary of third constituent –confirmation and disconfirmation

In this constituent the midwives' knowledge was confirmed by the discovery of the potential for the baby to be compromised, after a direct intervention was enacted, or the actual demise of a baby when this was predicted. On occasions confirmation would occur when the woman's birth was successfully expedited or if they remained in the area or hospital, birth would be imminent or the baby's condition would deteriorate. Confirmation would also arise for not choosing to work with a woman and another midwife similarly not finding the woman congenial; or undertaking a test and discovering an undiagnosed condition. Confirmation occurred across both specific and vague noticing and reflection was subsequently undertaken by the midwives which could further authenticate their practice as correct or help develop and hone their practice. When the knowledge was not confirmed there was an inherent lack of experiential knowledge to underpin it, or this enabled the view that intuitive knowledge was not absolute. Disconfirmation had varying effects on the midwives' utilisation of their intuition. For Debbie and Dee was the acknowledgement that intuition was linked with experiential knowledge and for Eleanor the sobering realisation that her intuition was not absolute.

The three constituents and their sub constituents have been expressed demonstrating the richness, complexity and interrelated character of the phenomenon under study. Fashioned from the constituents and the context of the midwives' unique practice milieu, the composite description is now presented. The justification for its use has already been presented within the methodology chapter, under the section entitled: *composite description* (see section 3.2.1.2, p.110)

The central rationale for the following section presenting the composite description is underpinned by a communicative concern to provide the reader with the rich texture of the midwives' experiences. The use of the personal pronoun 'I' to signpost the midwife as the first person illustrates the experience in a 'living and situated' context (Todres 2007).

The composite description was created by a re-reading of the midwives' transcripts, meaning units and transformed meaning units to create a situated picture of the context of the midwives practice. Elements of the context of all the midwives experiences were included especially if they were present in a number of the descriptions. Examples of this include the importance of a trusting relationship with the woman and her partner and the vulnerability of their professional status which was mentioned by all the midwives. Only a minority however mentioned relationship breakdown, but the majority mentioned utilising intuition to select women for care which stressed the importance they placed on a trusting relationship. The narrative of the composite description will now be presented.

4.2.2.6 A story of independent midwives' experiences of using intuition as a form of knowledge within their practice: A composite description

I have chosen to work outside the structure of the NHS to provide a way of working with my clients which enables the time and space to build trusting relationships. My work is vocational and a pathway I feel driven to follow. This provides a practice context that provides a dichotomy of both freedom and vulnerability. My freedom is the ability to work as an autonomous practitioner and my vulnerability is the possibility of relationships breaking down and the inherent risk of litigation and being reported to my professional body.

Requisite to enabling relationships to form is a connection with the woman and her partner. This provides a spark to ignite the flame that will light the journey of our relationship throughout her childbirth continuum. If this spark is not present we have to make a decision on whether or not to work with each other. Often this decision is mutual. If the woman however decides she wishes to employ my care, despite my lack of connection to her, my self-employment status may have a bearing on this in terms of whether I need the work. If I have the choice however I will generally choose not to work with the woman. This decision is underpinned by my sense of vulnerability as an independent practitioner and the increased possibility of being involved in litigation with my clients or reported to my professional body if interpersonal relationships break down.

I am aware of this connection through a bodily or emotional sense of noticing. If the connection is absent this is confirmed by future events such as the woman not communicating well or the relationship breaking down.

After initially getting to know the woman and her partner and mutually agreeing to work together, each subsequent contact brings us a little closer. My focus is not just on clinical care but prioritised on building a close relationship with the woman and her partner, my independent status enables the time to facilitate this process. During her pregnancy I start to perceive who she is, what she wants, I start to sense her pregnancy, her growing baby, her family. I intuit this knowledge through the reception of subtle nuances of her behaviour and communication. I know her sufficiently that the slightest look or intonation of voice will inform me whether all is not well with her health or pregnancy. This can occur during face to face visits or during a telephone call. I find if this intimate knowing of the woman is absent this can affect my intuitive ability. My intimate knowing enables me to sense what she needs to optimise her pregnancy and will increase the vigilance in my care or enact a specific intervention to fulfil these needs. Sometime this knowledge is brought by a dream or visual images, other times it is specific and directional. At times it can be a vague or generalised sense of foreboding. I sense specific or generalised noticing both physically and emotionally.

I constantly impart my scientific, clinical and experiential knowledge so we can work as partners in her care. This is undertaken at times juxtaposed to my intuitive noticing. I discuss my knowledge, concerns or suggestions with her enabling her to make decisions whether or not she refutes my views and feelings. I encourage her to connect with her body and baby and listen, observe and attend to this connection. Even if I think her baby is compromised I will never coerce her but only guide her into taking action. This saddens me at times as my knowing is generally correct; it is however my chosen path and her wishes and desires are at times centre to my care. At other times I have to make decisions rapidly her and her baby's safety are my utmost concerns. When she enters labour my sensing abilities are enhanced to

enable this. I observe her body and how it reacts. I encourage her to follow and trust her own body as I follow and trust my inner sense and knowledge. This enables me to suggest changes in her position and offer the use of my hands to aid the progress and optimise her labour and birth or act in a clinical emergency to improve and protect her and the baby's health and wellbeing. On other occasions it enables me to provide the woman with emotional care. When my noticing is vague or generalised I employ a heightened sense of vigilance to my care provision, this may include more observations, documentation and support from midwifery supervision.

My knowing in the majority of cases is confirmed by the unfolding pregnancy and birth events. Occasionally I am wrong however and this enables me to reflect that knowledge is not absolute.

My sense of knowing has developed over my life as a midwife. After each experience of labour and birth I learn a little more. With my inner sense of knowing I evaluate and reflect on each experience. This reflection has enabled me to realise that at times I am only intuitive if this is underpinned by my personal, historical knowledge. On other occasions I have experienced my intuitive knowledge being at odds with my empirical knowledge. In these circumstances I have listened to, prioritised and utilised my empirical knowledge only to subsequently find my intuitive knowledge evidenced as correct. This has enabled me to learn to trust my intuition more readily. I generally tend however only to use it juxtaposed to my personal, historical, ethical and empirical knowledge. This provides a catalogue of knowledge which I can draw on albeit at times unknowingly during future experiences. This has also provided me with knowledge that is unique and previously unrecorded which enables me to grow in strength as a midwife through a process of reflecting and honing my intuition and practice.

Having communicated the context of the midwives' intuition through a composite description the general structure (or essence) of the phenomenon will now be presented.

4.2.3 The general structure of midwives' experiences of utilising intuition

From the narrative of the composite description and the constituents, following the descriptive phenomenological method (Giorgi 2009) a further focusing has been undertaken to formulate the general structure of the phenomenon. The aim of formulating the general structure is to rigorously express the midwives' experiences of intuition and its utilisation within their practice in a coherent way. This essence is presented below:

This form of midwifery intuition occurs in a unique practice context where the midwife has vocationally chosen to work independently of the NHS and is chosen and privately employed by the woman and her family. Essential to this practice is a mutually trusting relationship between the woman, midwife and her family to protect the midwife from relationship breakdown, litigation and the possibility of being reported to the midwives' professional body. This relationship is founded on a mutual connection and then developed through the time and continuity independent practice affords. This provides the midwives with a relational way of knowing the woman and her baby. Through their relational way of knowing the midwives notice information about the woman and her baby. Two modes of information or knowledge were illuminated and typified as kinds of noticing. These comprise a vague or generalised form of noticing and a specific and directional form of noticing. Vague noticing presented itself as something the midwives could not fully describe or define and was frequently portrayed as noticing something general or not quite right about the woman. Specific and directional noticing would conversely convey a

specific image, information or definitive set of instructions or course of action to undertake. Both these forms of knowledge could occur in the absence of empirical evidence. This was however not always the case and sometimes intuitive knowledge would arise juxtaposed to scientific, clinical and situational knowledge. On most occasions integral to their intuitive knowledge would be the midwives' awareness and understanding of the woman.

The two types of knowledge were presented to the midwives through one of the following means of knowing: the reception of verbal and non-verbal cues, a bodily or emotionally sensed feeling, and the reception of an image or experiencing a dream. Both modes of knowledge could be intuited through these means; however the dream was a unique experience for one midwife and was limited to vague noticing. On many occasions integral to these forms of knowing or intuiting was an intimate connection to the woman and her family, however, this was not always the case as intuiting a bodily or emotionally sensed feeling and reception of verbal and non-verbal cues could occur on first meeting a woman and her family.

The vague or generalised or specific and directional knowledge revealed would either be utilised by the midwives by enacting an intervention or specific action or the provision of emotional care. On some occasions the midwives would choose not to act directly however would utilise their intuition by increasing vigilance in the care they provided.

Interventions would generally be undertaken when women the midwives were caring for were in labour. This was mostly following reception of specific and directional knowledge. The types of interventions would mainly be emergency measures to prevent mortality or morbidity of the baby or woman. Interventions

could also however be utilised to undertake a further diagnostic test to specify a potential problem during vague or generalised noticing, provide emotional care or specifically visit or stay with a woman unexpectedly.

Integral to midwives' intuitive knowledge was the consequences and the impact of utilising intuitive knowledge and how this became embedded within their lifeworld as a midwife. This concerned whether the midwives' experiences confirmed or disconfirmed the validity of their intuitive knowledge. This was experienced by the midwives in the following ways: confirmation of the nature of intuition and its juxtaposition with scientific, clinical and knowledge. This enabled the midwives to acknowledge the multiple forms of knowledge they utilised alongside their intuition and to aid its confirmation and further understanding. Confirmation which provided empowerment and supported intuition as an authoritative form of knowledge, enabled the midwives to value their intuition and demonstrated how its utilisation was embedded within the context of their independent practice, hospital constraints and their rational, situational and historical professional knowledge. Confirmation which reflectively honed present and future practice enabled the midwives to substantiate their existing practice, hone their multiple sources of knowledge and develop new forms of midwifery knowledge. Disconfirmation which reflectively honed present and future practice similarly enabled them to hone and comprehend further their intuition or realise through its disconfirmation it was not an absolute form of knowledge.

To further focus the essence of the general structure the following summary is presented.

4.2.3.1 The essential summary of the general structure

The most essential summary of the general structure of independent midwives experiences of utilising intuition within their practice will now be presented.

The *enabling context* for utilising midwifery intuition appeared to be the independent midwife's close and ongoing relation with the woman. The general structure of the experience is essentially made up of three components: *the process of knowing, the utilisation of this knowing, and the confirmation or disconfirmation of the validity of the intuition and its meaning for the practitioner.*

4.2.3.1.1 The process of knowing

There are two essential components to '*the process of knowing*'; firstly, the different ways that the independent midwife comes to know, entitled '*kinds of noticing*'; and secondly, the '*kinds of knowledge*' that is revealed by these ways of knowing. The '*kinds of knowing*' include the reception of subtle cues, own emotions, bodily felt sensations, images and dreams. These are all alternative or complimentary ways of knowing to what is usually considered as scientific or evidence-based ways of knowing. The kinds of knowledge that the different kinds of noticing essentially reveal include non-specific knowledge, and specific knowledge. An example of non-specific knowledge concerns vague information that something may not quite be right. An example of specific knowledge is where specific information is revealed such as the likelihood of an obstetric emergency, or directional information such as the strong impulse to perform an action.

4.2.3.1.2 The utilisation of the intuited knowledge

The intuitions could be acted upon in a number of ways, but essentially, this appeared to depend on whether the intuited knowledge was specific or non-specific. When informed by specific knowledge, the range of utilising included: the provision of bereavement support, providing the woman with physical support during labour or changing a woman's position during birth. When informed by non-specific knowledge the range of indirect utilising included: the increase alertness and vigilance in a woman's care by increasing assessment of the woman's and baby's condition; or the timely preparation of emergency equipment.

4.2.3.1.3 Confirmation or disconfirmation of the validity of the intuition and its meaning for the practitioner

The validity of the intuitions are often confirmed or disconfirmed by subsequent experience or evidence. When they are confirmed they tend to result in one or more of the following kinds of consequences: a further authentication of the independent midwives' practice as correct or to provide assistance to develop and hone their practice. When they are disconfirmed, this tends to result in the following types of consequences: the realisation that personal intuition is absent when there is an inherent lack of experiential knowledge to underpin it, or the view that intuitive knowledge was not absolute.

The detailed stories further revealed that midwifery intuition, although distinctive, is a complex phenomenon which is utilised in conjunction with, (sometimes in tension with, sometimes complimentary to) other forms of knowing such as scientific knowledge, historical and professional experience, and ongoing reflection and

feedback. Independent midwifery intuition is thus a partner in an inclusive conversation that is potentially able to refine and enhance midwifery practice as a holistic pursuit which draws on a range of epistemological resources.

The relationship between the constituents will now be presented.

4.2.4 The relationship between the constituents

The relationship between the constituents and how they function constitutively is implicit within the general structure and composite description, to enable them however to be explicit and to provide transparency for the reader a series of diagrams have been created. These demonstrate the interrelation of the constituents between each other. Due to the confines of the diagrams the integral parts of the constituents have been abridged, each diagram however demonstrates how the constituents connect together. This includes the kinds of noticing and information revealed, how it was utilised and confirmed or disconfirmed. A selection of experiences have been selected which represent all sides of the phenomenon. Some of the sub constituents within the kinds of noticing were more prolific in the midwives' experiences. These were essentially: *'specific noticing through the reception of cues'* and *'specific or directional noticing through an emotionally or bodily felt sensation'*. Conversely, there was a dearth of examples within the sub constituents concerning *'specific and vague abstract images'* and *'dreams'* and *'specific noticing through an emotion'*. The following diagrams signify the representations of the experiences. This is not to address a quantitative concern which is directly opposed to the descriptive phenomenological research methodology. This representation has been selected to illuminate the colour and

dimensions of the constituents and their interrelation. For clarity for the reader the squares shaded purple, orange and blue are examples of the individual constituents and these have been grouped together as sub constituents.

The first diagram (figure 4:1, p. 196) presents diagrammatically examples of how the sub constituents '*non-specific or generalised noticing through the reception of cues*' interrelated throughout the constituents '*kinds of utilisation*' and '*kinds of confirmation*'.

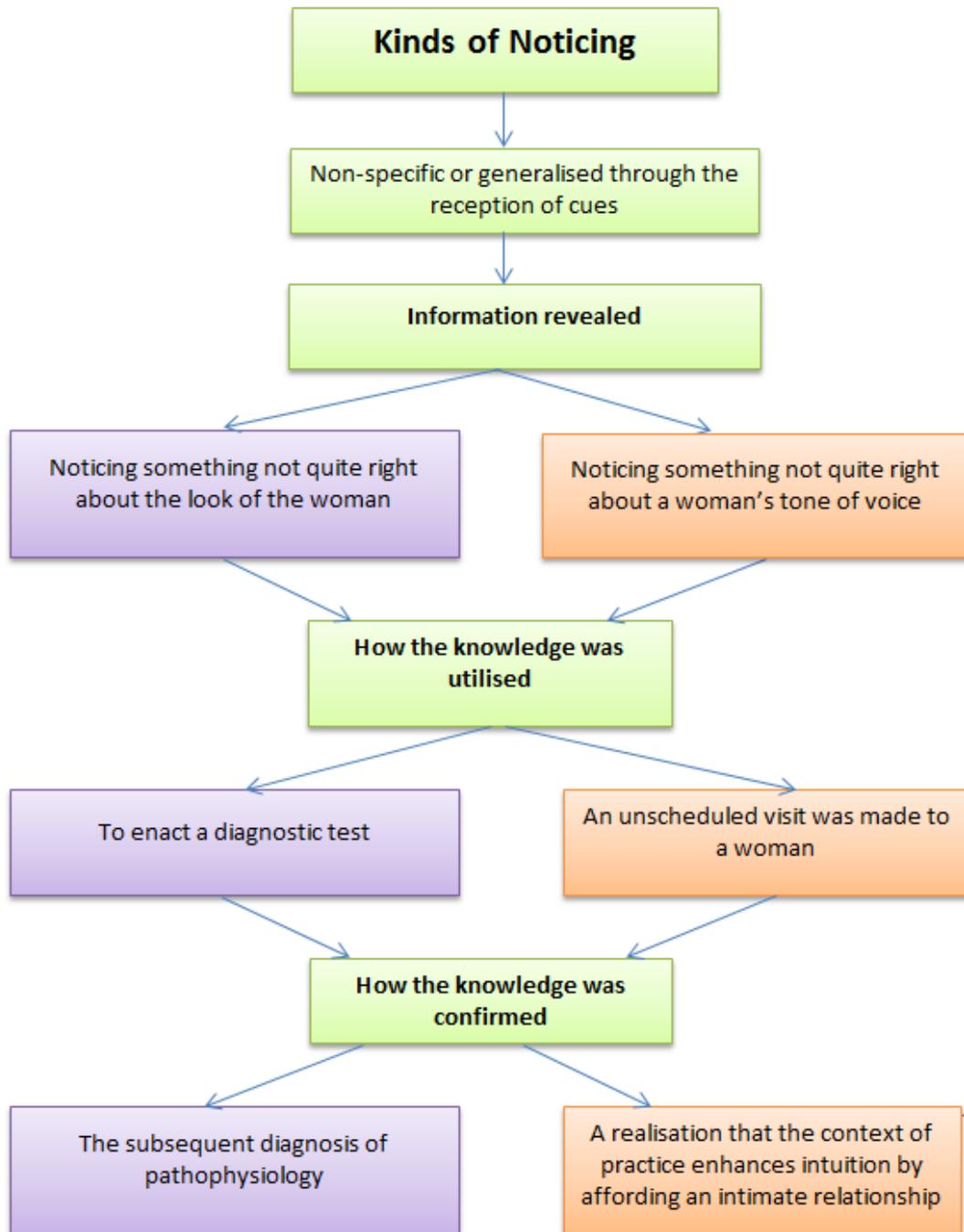


Figure 4:1: Non-specific or generalised noticing through the reception of cues

The second diagram (figure 4:2, p. 197) presents diagrammatically examples of how the sub constituents '*non-specific or generalised noticing through a bodily or emotionally felt sensation, an abstract image or a dream*' interrelated throughout the constituents '*kinds of utilisation*' and '*kinds of confirmation*'.

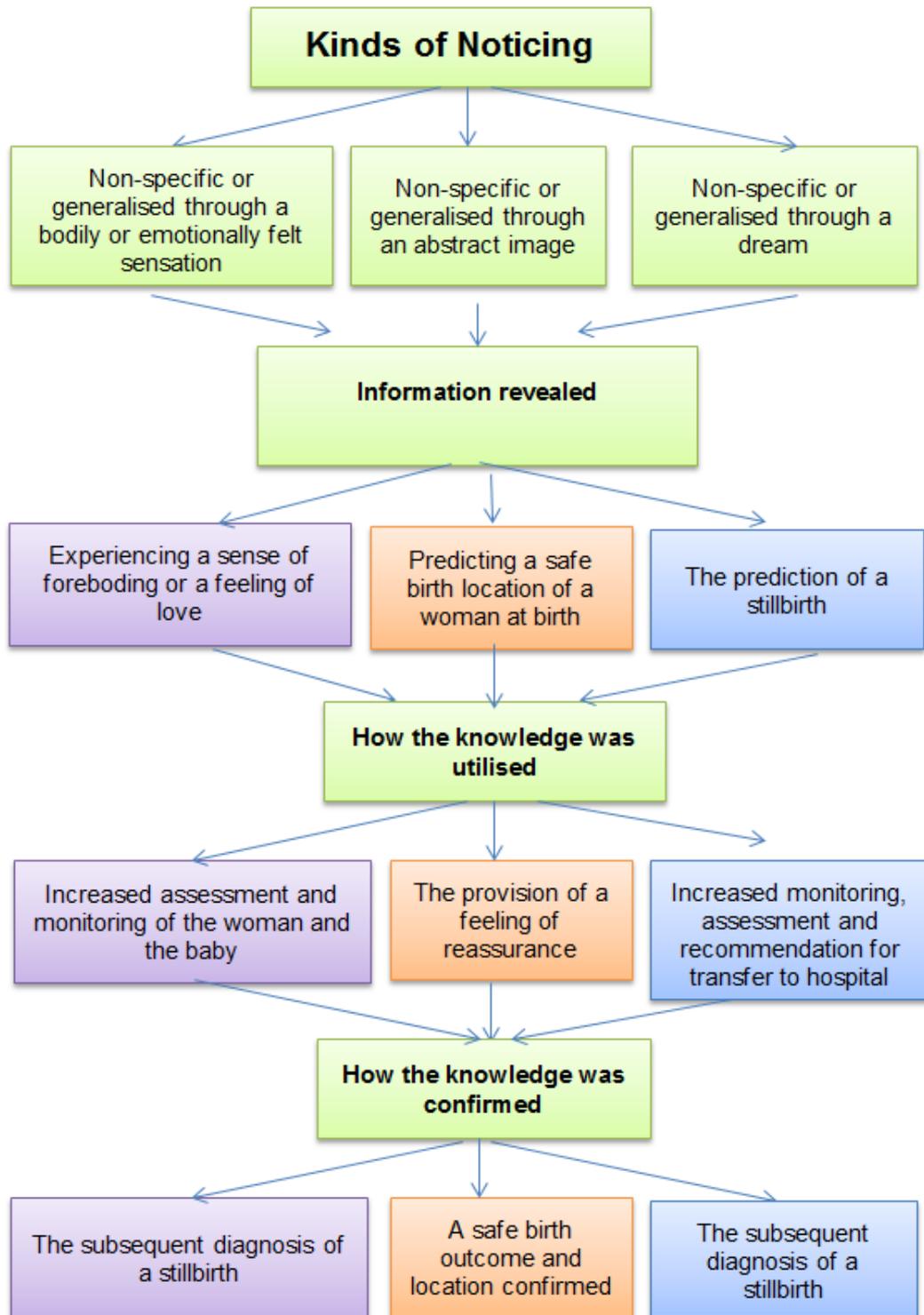


Figure 4:2: Non-specific or generalised noticing through a bodily or emotionally felt sensation

The third diagram (figure 4:3, p. 199) presents diagrammatically examples of how the sub constituents ‘*specific or directional noticing through the reception of cues*’ interrelated throughout the constituents ‘*kinds of utilisation*’ and ‘*kinds of confirmation*’.

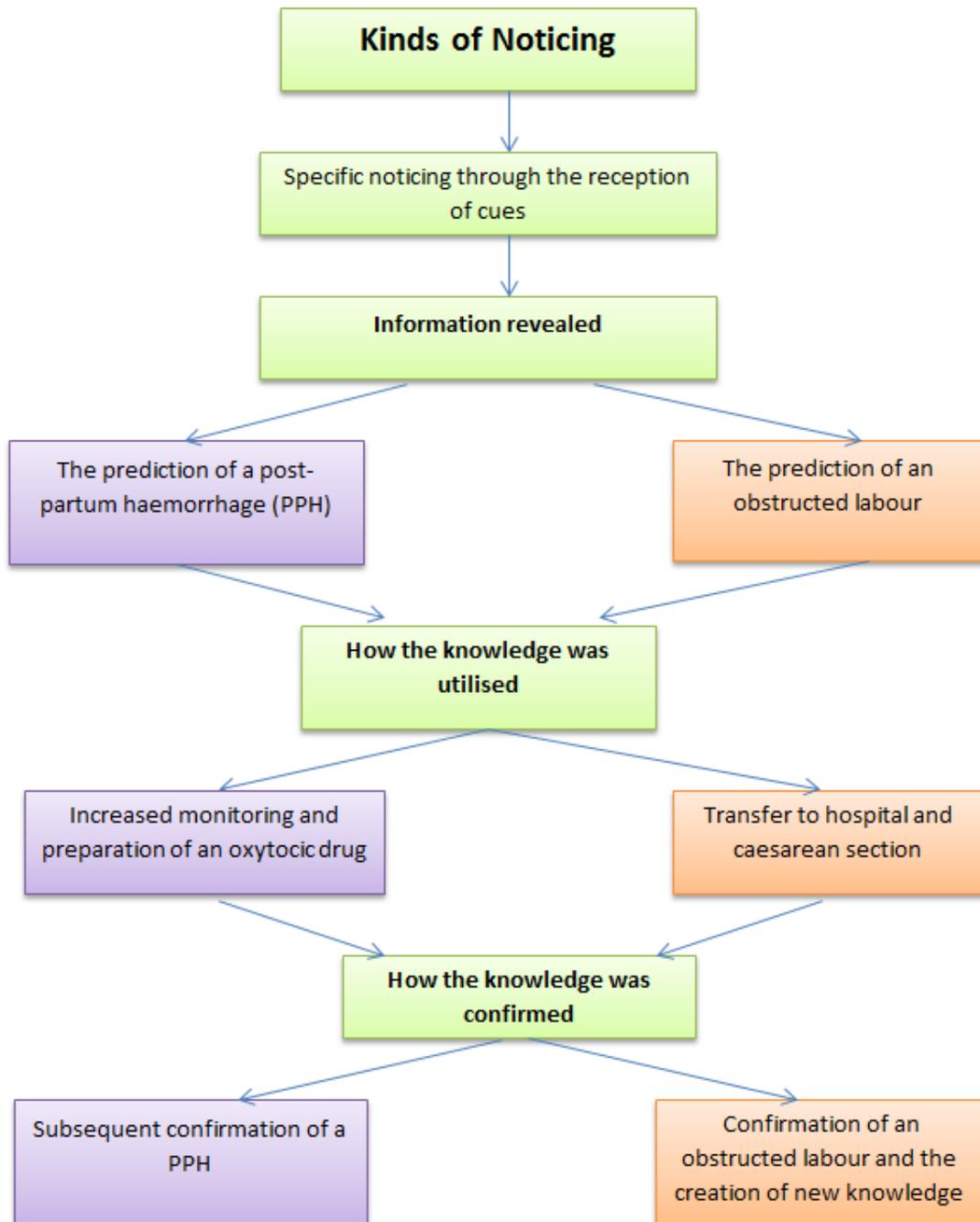


Figure 4:3: Specific or directional noticing through the reception of cues

The fourth diagram (figure 4:4, p.200) presents diagrammatically more examples of the sub constituent 'specific or directional noticing through the reception of cues'.

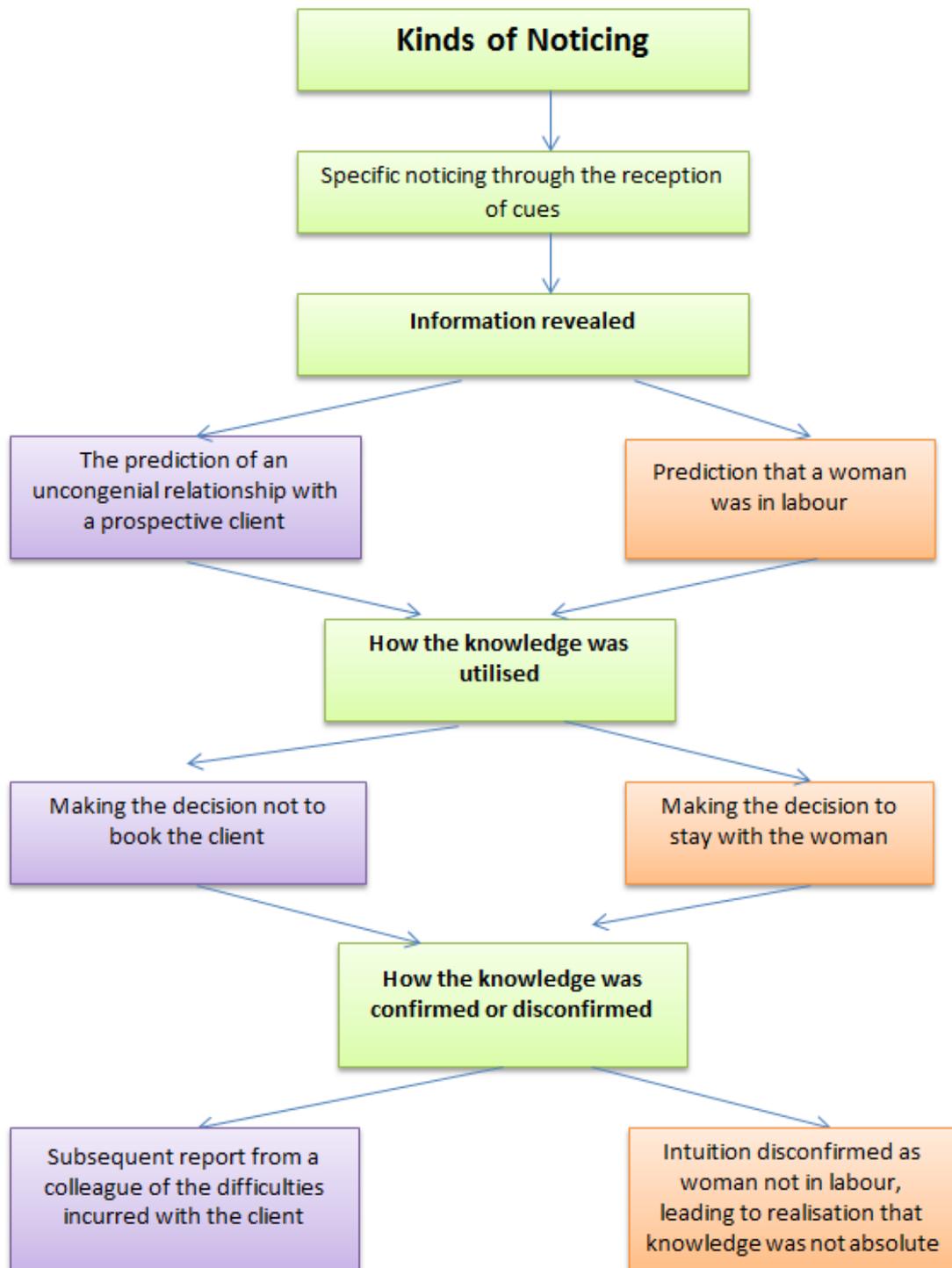


Figure 4:4: Specific or directional noticing through the reception of cues

The fifth diagram (figure 4:5, p.200) presents diagrammatically examples of how the sub constituent '*directional noticing through a bodily felt sensation*' interrelated throughout the constituents '*kinds of utilisation*' and '*kinds of confirmation*'.

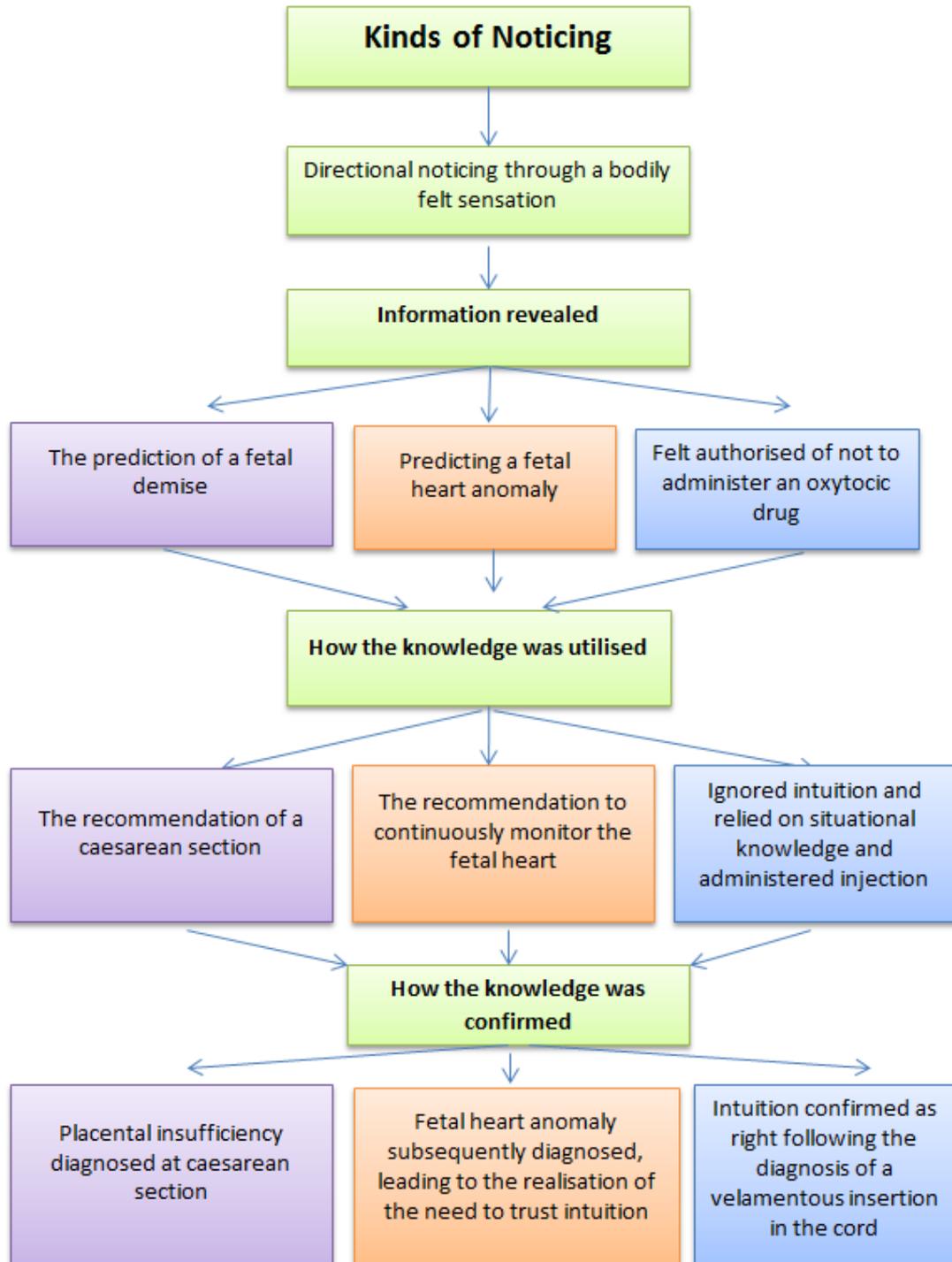


Figure 4:5: Directional noticing through a bodily felt sensation

The sixth diagram (figure 4:6, p.202) presents diagrammatically examples of how the sub constituent ‘*directional noticing through an emotionally felt sensation*’ interrelated throughout the constituents ‘*kinds of utilisation*’ and ‘*kinds of confirmation*’.

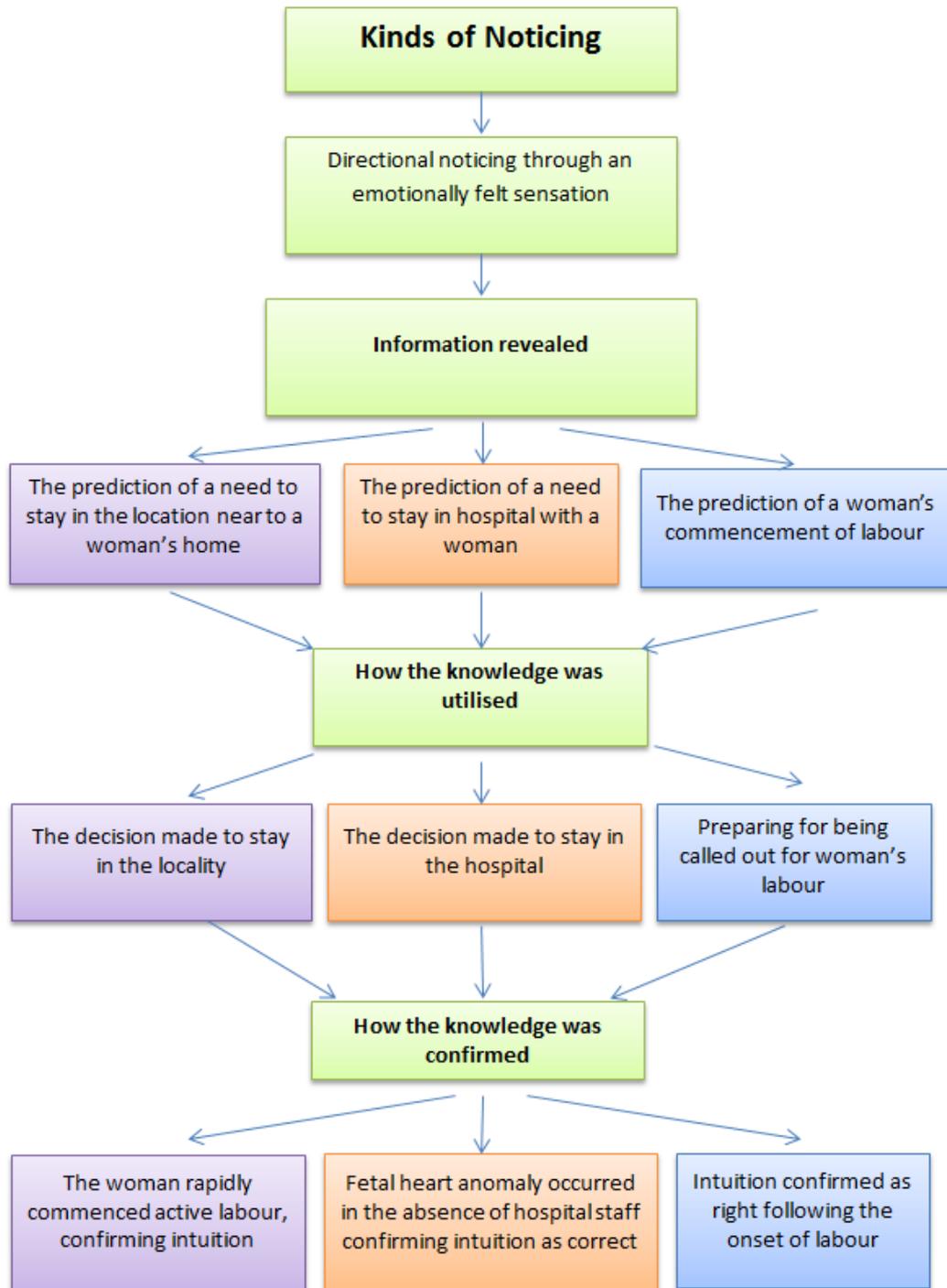


Figure 4:6: Directional noticing through emotionally felt sensation

The seventh diagram (figure 4:7, p. 204) presents diagrammatically more examples of the sub constituent '*directional noticing through an emotionally felt sensation*'.

The eight diagram (figure 4:8, p. 205) presents diagrammatically examples of how the sub constituents '*specific noticing through informational and abstract images*' interrelated throughout the constituents '*kinds of utilisation*' and '*kinds of confirmation*'.

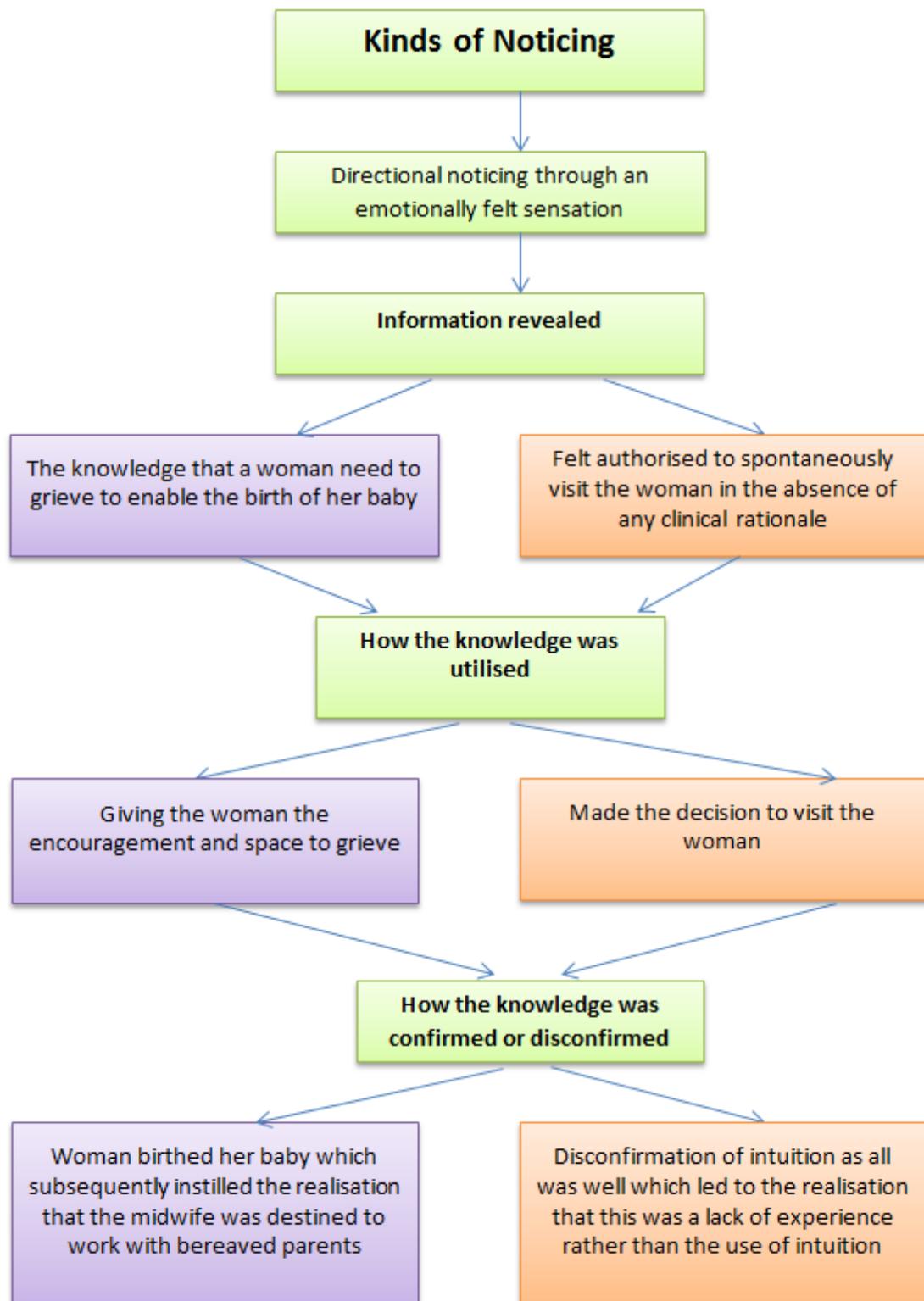


Figure 4:7: Directional noticing through an emotionally felt sensation.

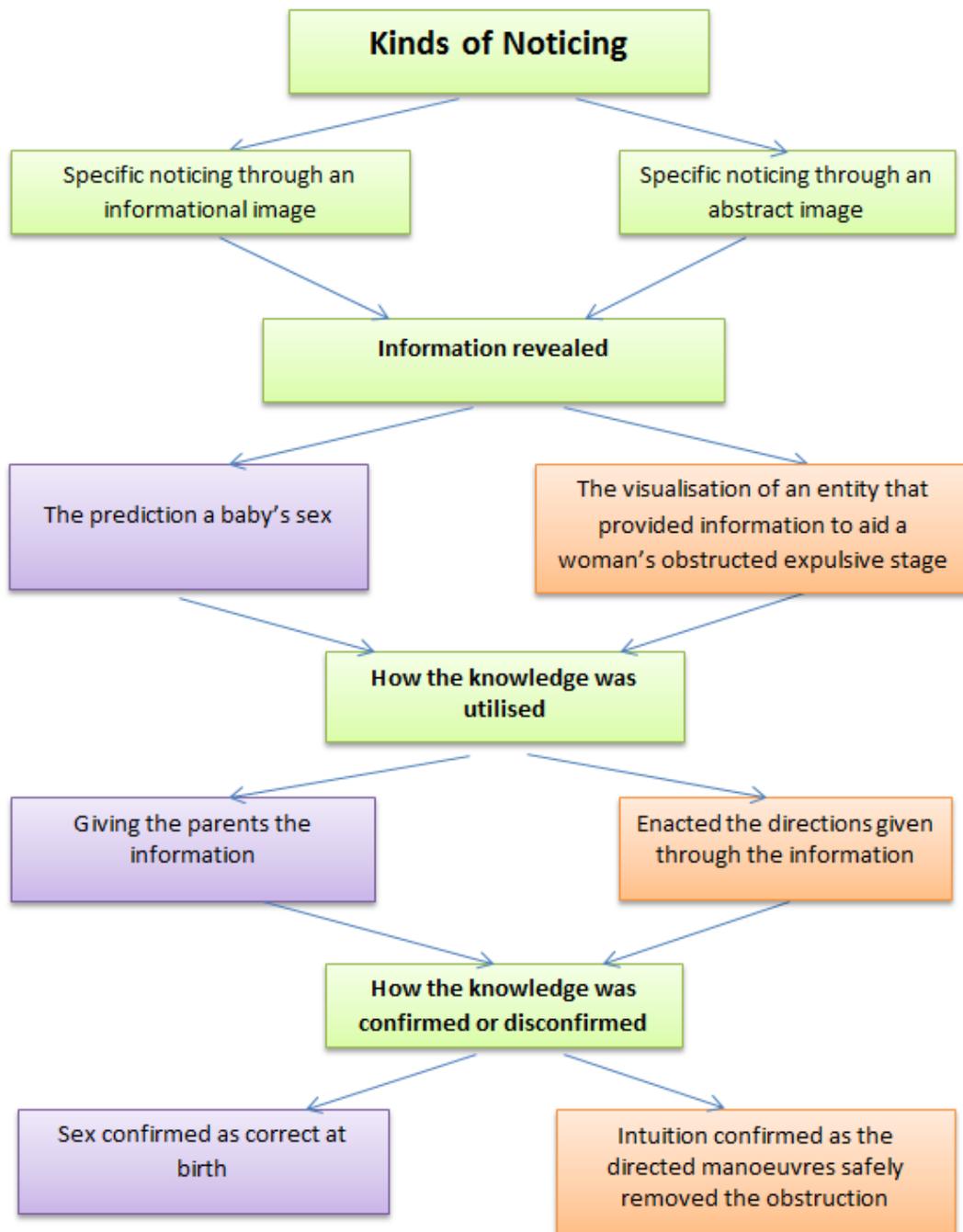


Figure 4:8: Specific noticing through informational and abstract images

These diagrams have demonstrated how and what the midwives noticing explicitly consisted of and exactly how it could be utilised and confirmed, or disconfirmed and

utilised for empowerment and authorisation. This has demonstrated the intimate interrelation of the constituents and how they fit together as a whole.

The presentation of the general structure and the interrelation of the constituents have enabled an explication of the 'whatness' of the midwives' intuition. This has addressed the scientific concern and rigour of the study. The composite description has provided context for the midwives' experiences which has partly addressed the communicative concerns of the study. This however has not fully addressed this need. It is now necessary to present the essential structure's embodied interpretation. This is to further address this communicative concern and provide resonance for the reader of the midwives' lifeworlds and experiences of intuition.

4.2.5 The embodied interpretation of the general structure

The embodied interpretation presents a secondary phase of analysis. The aim of this further stage is to present a more evocative, nuanced way of expressing the general structure (Todres and Galvin 2006). The rationale for this stage has already been presented in the methods section 3.2.1.3 (p.111). My aim in interpreting the structure in an embodied way is to touch the reader more profoundly, leaving them with an essence of the independent midwives' artistry in their utilisation and experiences of intuition. This was created following a re-reading of the general structure on a number of occasions, and a search for an empathic meaning in the structures was then undertaken. The embodied interpretation has been entitled 'the midwife's journey of knowing' as this represented the narrative flow from within the general structure and is now presented as the final part of the findings.

The midwife's journey of knowing

I chose to work independently

To create the time and space to know you.

We meet, there are sparks, and we bond.

We walk together in your childbirth journey.

We make time to connect and know each other

You get under my skin, when I'm not with you, you are in my mind.

You learn to trust me. I learn to trust you.

This is vital for our connection.

When I'm with you I breathe you in. I feel your heart beat. I sense your thoughts, your body, and your soul.

I sense the life growing inside you, your baby's uniqueness. I sense your body and your baby's growing ability to cope with the pressures of new life.

I see you through nuanced signals

Noticing how you speak and how your body communicates.

I feel you within my body

Noticing my bodily movements.

I sense you within my emotions

Noticing on occasions my own anxieties and feeling of love.

These feelings merge and grow as your body blossoms.

I visualise images

Noticing guardians of your birth,

And your baby's identity.

I sense you in my dreams

Noticing your journey, your baby's destiny.

I dwell within myself and feel your needs,

I learn from you, from your own uniqueness and the new life inside you

I make connections;

Sometimes my knowing is unique and alone

Sometimes it is joined with knowing from previous journeys and other worldly knowing.

I sense when your pathway is smooth

I sense when your pathway is rough.

I sense what is right for you

At times I am commanded to act, but I am your guardian, your guide. I will only take you where you wish to go.

When labour awakes within you my knowing is heightened

Only then do I act swiftly for you both

From my knowing I learn from my journey

Crafting my knowledge from victories and questions.

From joys and sorrows

Like the circle of life

Learning and feeling,

Learning and knowing

Learning and living.

It is hoped that this embodied interpretation has a rhythm that the reader can resonate and connect with. Utilising a translation of the essential structure,

constituents and composite description, evocative words have been chosen which embody the midwives' experiences of intuition and its context.

This chapter has presented the findings of the study. The essence of the phenomenon has been presented as constituents and a general structure to address the scientific concern and a composite description and an embodied interpretation has served to address the communicative concern of the study.

The next chapter will now consider the findings in the context of how they resonated or disconfirmed the associated scholarship regarding intuition. New insights to the phenomenon will be explicated that have been enabled by the rigour of the descriptive phenomenological research methodology and methods.

Chapter 5 The elaboration of the findings in relation to relevant scholarship and the implications for practice and education

This chapter will discuss the findings of the study and implications for scholarship, practice and education. The previous chapter did not analyse the relevant literature and research alongside the findings in order to support phenomenological methodology which requires a sole description of the midwives' experiences. A further chapter is therefore necessitated to accomplish this analysis. This chapter will also analyse the contributions this study has made to the scholarship on intuition. These insights will be further discussed in terms of their implications and recommendations for practice and education. In the spirit of the phenomenological research method, this chapter will commence with a personal narrative reflecting on the original aims of the study or "articulating an experiential phenomenon of interest for study" (Todres and Holloway 2004, p. 84). This will express how and whether the research process answered the original research questions. Similar to other sections of the thesis, the use of the first person will be utilised to denote personal responsibility and authority of the written text (Webb 1992).

5.1 A reflective personal narrative -revisiting the aims of the study

As a midwife and an educationalist my key driver for the study stemmed from an interest in forms of midwifery practice knowledge. This quest gained impetus as the prioritised form of knowledge within the NHS became dominated by evidence based practice (Olatunbosun et al. 1998; Nakielski 2005). Concomitantly, other forms of midwifery artistry such as intuition were marginalised as they did not fit into the

construct of evidence based practice (Davis-Floyd and Davis 1997; Wickham 2004). Without having the necessary tools to record intuition and the nature of intuition being diffuse and difficult to rationalise there was a danger that this knowledge could be subsumed by the hegemonic paradigm of evidence based practice (Wickham 2004).

Leading midwives, epistemologists and educationalists however had hailed the use of intuition as being integral to practice knowledge (Davis-Floyd and Sargent 1997; Wickham 1999; Polkinghorne 2004; Brown 2006) and having personally experienced intuition in my own midwifery practice and seen it utilised by midwifery colleagues, my interest became centred on investigating the phenomenon further. This interest became additionally fuelled by the dearth of evidence of intuition and its utilisation in midwifery practice. Having the informed belief that the realm of intuitive knowledge existed provided a quest for the phenomenon to be clarified. This was underpinned by the aim to enable students to be initiated into this form of knowing and for practitioners to develop and increase expertise in this area.

A literature search revealed a plethora of associated terminology including *perception via the unconscious* (Jung 1971a; Bargh and Morsella 2008) *intuition*, (Davis-Floyd and Davis 1997), *aesthetic knowing* (Carper 1978), *patterning* (Benner 1984) *tacit knowing and knowledge* (Benner and Wrubel 1989; Polanyi 1966), *reflexivity and reflection in action* (Johns 1998) *embodied knowledge* (Polkinghorne 2004), and *intuition in the context of decision making* (Noseworthy et al. 2013). Each of these definitions elaborated on different theories of practice and intuitive knowledge; however there appeared to be no consensus or clarity as to the nature or essence of intuition and the majority of this evidence stemmed from nursing inquiry and theorists. A further dimension revealed the proposal of an *intimate*

connection between the practitioner and patient, or midwife and woman (Davis-Floyd and Davis 1997; Ólafsdóttir 2009; Barker 2011). It was not clear however whether this intimacy was central to intuition or an associated factor.

The decision was made to collect data from a purposive sample of midwives who had experienced intuition. To enable a depth and richness of data, a cohort was selected whose ways of working enabled the utilisation of multiple forms of knowledge as their practice was independent of the NHS. This cohort also offered continuity to women in their care which could enable intimate ways of knowing or an interpersonal connection.

5.1.1 The research questions

The research questions were then formulated: that if intuition did exist within this cohort group of independent midwives *what form did it take? How and why did they utilise it? And was there a particular context in which it existed?* The study provided a range of insights to these original questions in the following ways.

5.1.2 The what of intuition....

The nature of the midwives' intuition was divided into two areas: firstly the intimate knowing or noticing of the woman which included the reception of subtle cues, own emotions, bodily felt sensations, images and dreams and secondly, the revelation of knowledge the midwives' intuition would provide. This knowledge was either non-specific or generalised such as noticing something not quite right about a woman or

specific, such as the prediction of an obstetric emergency. This knowledge could also be directional such as guidance during an emergency birth procedure.

5.1.3 The how of intuition....

The general structure of the phenomenon under study revealed how intuition was utilised both directly and indirectly. Its direct use involved the enactment of an intervention or the recommendation for specific elements of care. When not directly utilised it was indirectly used to increase alertness and vigilance in a woman's care by increasing assessment of the woman's and baby's condition. The study revealed not only how intuition was used in practice but also how intuition could be honed and developed through the midwives' continuing practice. This included the development of new midwifery knowledge that has previously not been formally recorded. This was through the process of confirmation and disconfirmation of the midwives' intuition enabling them to integrate it into their lifeworlds. When the knowledge was not confirmed there was an inherent lack of experiential knowledge to underpin it, or informed the midwives that their intuitive knowledge was not absolute.

The independent midwives' intuition however was not unrelated to the logic of evidence albeit in a first person developmental way. Their intuition had a form of rationality even though it was based on initial holistic *noticing-a* perception that could not immediately be rationalised, however at times could be on subsequent reflection.

5.1.4 The why of intuition.....

The study revealed a rich complexity as to why and when intuition was used. On some occasions the independent midwives would utilise their intuition immediately and seemingly without recourse to other forms of knowing. This immediacy of acting on their intuition was confined generally to emergency situations during labour, when timely decision making is imperative. On other occasions however, utilisation of intuition would be juxtaposed with empirical or situational knowledge or the midwives' sense of ethical practice. This positioning of intuition enabled it to become an authoritative part of the independent midwives' practice knowledge and decision making.

5.1.5 The context in which it existed....

The context of the midwives' intuition was inextricably linked with an intimate knowing and connection to the woman. Intimate knowing was enabled by the model of continuity of care the independent midwives adopted. Continuity was enhanced by the wealth of time independent practice allowed. The intimate connection comprised a holistic form of knowing embracing physical, social, psychological and spiritual elements of the woman. This connection was necessary to both protect the midwife against relationship breakdown and possible subsequent litigation by their initial selection of their clients and served to enhance the midwives' perception of their intuition.

Having presented how the research questions were answered, the implications for scholarship, education and practice will now be considered.

5.2 Implications for scholarship

The implications for scholarship will consider how the findings of the study qualified, resonated with or disconfirmed the existing academic literature on intuition and its utilisation in practice. New insights revealed by the study will be identified and comparative relevant literature will be analysed. This will illuminate confirmation or disconfirmation of any existing theories or research on intuition and its utilisation in practice. In addition to re-visiting literature that was explored in the conceptual review, it is necessary to introduce further literature that was not originally included as the study illuminated elements that were not found when researching for the conceptual meanings of intuition.

In line with the spirit of descriptive phenomenology: '*back to the things themselves*' (Husserl 1900a), examples from the findings will be utilised to clarify the analysis of the literature. Whilst it is recognised that within a grounded theory study, for example, the most appropriate place for this would have been solely within the findings chapter (Baker et al.1992), in a phenomenological study it is more fitting for this interpretive phase to be included within the discussion chapter (Giorgi 2009).

The findings in essence revealed the following range of insights on the nature of intuition and its utilisation: the identification of the elements of intuition; the complexity and prioritisation of intuition and other forms of knowledge when acting in practice and finally, how intuition can be further developed through a process of reflection. The implications for scholarship will first be presented followed by the implications for practice and education. The next section will consider the identification of the elements of intuition within the midwives' experiences and

compare it to the existing literature concerning intuition, and its associated terminology.

5.2.1 The identification of the elements of intuition and the implications for scholarship

Within the research and literature, there is a lack of clarity surrounding the definition of intuition. It is asserted that this study has provided some amelioration to this knowledge gap by creating a further level of transparency to the phenomenon of intuition and its related terminology. The study has additionally illuminated some associated factors which are identified as integral to intuition. These are illustrated in figure 5:1 entitled '*The range of the process of intuitive noticing and the information it revealed*' (p.235). The scholarship surrounding intuition has lacked clarity and affirmation and has failed to describe what constitutes intuition. For example, terminology such as 'tacit knowledge' is often utilised to describe intuition. This has created a problem in accepting intuition as an authoritative form of knowledge, as it is not instantaneously accessible from rational thought processes (Carlsson et al. 2002).

This study, however, clearly identified a range of not only the process of how intuition is perceived (see figure 5:2, p.236, entitled '*Vague noticing*') and figure 5:3 (p.237 entitled '*Specific or Directional Specific noticing*') but also the types of knowledge it reveals (see figure 5:4, p. 238 entitled '*The knowledge or information revealed through noticing*'). The relationship, process and range of the independent midwives intuitive knowing and its concomitant knowledge were illuminated by this

study. This has provided evidence to support the credibility of the use of intuition in practice enabling its utilisation as a legitimate form of knowledge.

The main insight illuminated was a typography of both the process of knowing and information revealed through the independent midwives' intuition. In the literature there appeared however to be lack of definition between the concepts of the process of knowing and the concomitant knowledge illuminated. Within the scholarship on intuition theorists and researchers have tended to focus on it being a type of practice knowledge that is not easily accessible or *tacit* and the majority of the associated literature which analyses intuition as a form of knowing or knowledge has centred on the terms *tacit knowing* and *knowledge* (Benner and Wrubel 1989; Johns 2000). There is however, confusion as to whether tacit knowing or knowledge are separate or related entities, and if related how their connection exists (Toom 2012). The specific detail of these dilemmas will now be presented juxtaposed to examples from the midwives' experiences to contextualise the range of their intuition. This range described by the midwives will be comparatively analysed with existing examples from the available literature to illuminate insights of the elements of what constituted the midwives' intuition.

Johns (1998, p.2) has asserted that intuition is a form of "tacit knowing", Johns (2000) does however utilise the terms *tacit knowing* and *knowledge* interchangeably. Johns (2000) advocated reflection as a process for uncovering tacit knowing or knowledge. The midwives' descriptions of '*kinds of vague*' (see section 4.2.2.2.1, p. 126) and '*specific or directional noticing*' (see section 4.2.2.3.1, p.138) '*through the reception of cues*' explicated one means of the range of the midwives' process of knowing. The data revealed that on a number of occasions the midwives could not specifically define that they had received or noticed cues. This

would concur with Johns' (1998, p.2) definition of intuition being *tacit* knowing as the midwives could not clearly define how they knew. They were however able to realise when they reflected on the event it was the reception of cues that elicited the knowledge that something was not quite right about the woman, or predicting that the woman was going to bleed. This confirms Johns' (2000) assertion that reflection can clarify tacit knowing. Buckingham and Adams (2000) have previously identified the reception of cues with tacit knowing however this connection was concerned with heuristics. Cues were reported in terms of novices learning to link rules with a pattern of symptoms, which then became unconscious or tacit. The independent midwives' holistic noticing of cues however appeared to uniquely relay intuitive information albeit at times, vague.

Benner and Wrubel (1989, p.6) have described intuition as "know how", or how we know, which would suggest a means or process of knowing. They do however further define 'know how' as tacit knowledge that is associated with a created understanding of a situation without having a rationale, once again utilising the terms interchangeably. Both Bourdieu (1990) and Benner et al. (2010) have asserted that as practitioners develop experience their conscious knowledge of practice becomes tacit. What is not defined, however, is whether they are referring to the process of knowing or the content of the knowledge revealed. Benner et al. (2010, p. 178) have termed this as "patterning". In her seminal study of nurses' expertise she concluded that intuition could be diminished if intuitive or 'expert' practitioners tried to analyse their performance (Benner 1984). The independent midwives however were able to realise when they reflected on the event it was the reception of cues, for example, that elicited the knowledge that something was not quite right about the woman. It could be construed that this could enhance their performance, rather than diminish it as it enabled comprehension of their knowing

which they could then hone and then utilise to develop their practice further. This illustrates that the midwives realised not only what they knew, albeit vague, or tacit, on some occasions, for example that something was not quite right about the woman, but also an awareness of how they had perceived this knowledge: through the reception of cues. This clarification of their intuition confirms Johns' (1998, p.2) attestation that reflection is a means of access to previous experiences in order to develop "the reservoir of tacit knowing". When on some occasions, in the midwives' experiences, reflection was required to identify the reception of cues, this would occur generally when they deemed that there was something was 'not quite right' about a woman, which on further reflection would identify a non-verbal cue, albeit vaguely.

Sometimes, however, within the independent midwives' experiences cues were instantly recognisable and clearly defined. This proposes that intuitive knowing is not always tacit which contests Benner's (1984) and John's (1998) assertions, however confirms John's (1998) views on accessing tacit knowledge through reflection. It also highlights how intuitive noticing through cues existed differently for different midwives in the study broadening the range and definition of their intuitive knowing.

It has been identified that both Benner (1984) and Johns (1998) blur the concepts of knowing and knowledge, and throughout the associated literature these terms are frequently interchangeable. Toom (2012) is the only theorist who attempts to provide some amelioration to this dilemma through an analysis of the epistemology of *tacit knowledge* and *knowing*. It is acknowledged however that Toom (2012) has undertaken an exploration of the existing literature and not conducted primary research. In this review, Toom (2012, p. 640) provides a distinction between

knowing or “the owner of knowledge” and knowledge as “the nature of knowledge”. She also distinguishes between the “process” of tacit knowing and the “product” or content of tacit knowledge (Toom 2012, p. 640). Toom (2012, p. 640) conceptualises tacit knowing as:

“a process, which is realized through the skilful and competent action of professionals. It is possible to articulate it retrospectively”.

The idea that knowing can be articulated resonated with the midwives’ experiences of knowing as the midwives *could* articulate their means of knowing as experiencing a dream or the reception of an image for example. The knowledge revealed however could be vague and unspecific, for example the knowledge that something was not quite right. Toom’s (2012) definition of tacit knowing however appears to relate to how the knowledge was utilised, indicated by her use of the word *action*, rather than the way it was perceived, or a means of knowing. The term *realizes* however appears to refer to a means of perception, but this is not further explicated within her paper. She does however acknowledge the process and product dimensions of tacit knowledge are not mutually exclusive however exist in a reciprocal relation with each other. Toom (2012, p. 640) refers to the “product” of tacit knowledge as:

“the implicit knowledge that encompasses embedded beliefs, attitudes, and values, tacit knowledge is only partly knowable, and thus its thorough articulation might be difficult. “

This concept resonated with the independent midwives experiences as their knowledge was at times difficult to articulate particularly in the sub constituents incorporating ‘*vague noticing*’, however in terms of its association with beliefs and attitudes the midwives would engineer these beliefs when making the decision whether or not to utilise their intuitive knowledge rather than this being integral to their knowledge.

Polanyi (1966) has acknowledged that the elucidation of actual knowledge gleaned by tacit knowing remains difficult. Polanyi's (1966, p.8) basic premise of human knowledge is that "we can know more than we can tell". In his seminal philosophical work on practice knowledge entitled 'the tacit dimension' Polanyi (1966, p.8) does however conceptualise the origin of intuition and described tacit knowledge as being based on two types of awareness: "focal" and "subsidiary". Focal awareness was described as conscious and directed whereas subsidiary awareness was conceptualised as unconscious or silently sounding out to detect possible relevant data. This could be deemed as a means of knowing rather than knowledge itself, although the term *knowledge* is cited. Polanyi (1966) believed a conscious shift could occur between these two paradigms and asserted that tacit awareness rested between the two. This definition does appear quite complex, it is asserted however that the independent midwives' actual knowing was more transparent: through the reception of cues or an image, for example, which could be compared to Polanyi's subsidiary awareness, albeit in a more specific way.

Polanyi (1968, p.107) coins the process of intuitive knowing as artistry achieved through practice skills or: "knowing as an art, as a skill of the knower". The midwives' tangible forms of knowing could be compared to Polanyi's (1968) assertion: their ways of knowing, especially the reception of cues related to their practice skills, similarly, being receptive to emotions and bodily feelings could also be described as a skill. Polanyi (1968) further described these skills as awareness. The reception of a dream and images however could be considered as falling outside the domain of a skill, however these experiences could be conceptualised as a form of awareness. As this is a rare side of the phenomenon, this however remains conjecture.

Whilst the identification of cues has not been described as a means of intuitive knowing within the literature, a ubiquitous synonym for the process of knowing that has been previously identified is 'gut feeling'. This relates in essence to the independent midwives' bodily felt sensations. The midwives on occasions utilised this visceral term, however more specific descriptive terminology was also used such as "sick feeling", "belly ache" or "wind". Sometimes however, this tangibility could be blurred for example when the midwives would utilise the term *gut instinct* to describe their intuitive knowing, seemingly alluding to a bodily felt sensation however when reflecting on the event on some occasions, they would identify the reception of cues. This appears once again to demonstrate that the midwives' means of tacit knowing could be revealed through reflection (Johns 1998). Barker (2011) similarly cites the term 'gut instinct' in her study researching midwives' emotional care of women becoming mothers. Barker (2011) relates how midwives would use their gut instincts to guide them in their facilitation of care. This does appear to identify a process of bodily sensed knowing 'through the gut' and intuitive knowledge identified as the guide of care necessitated. There is no description however of exactly how the gut feeling happened to be felt. Davis Floyd and Davis (1997, p.145) refer more specifically to gut instinct as:

"the knowing that comes to us from the inside of our bodies, arising as a gut feeling, an intuition".

Davis Floyd and David (1997) in their qualitative study of homebirth midwives from the USA reported that their cohort of midwives would sometimes describe the origin of their intuitive connection with women as a physical sensation. Davis Floyd and David (1997) reported that the home birth midwives believed they had to be 'open' to receive this form of intuition not only to the women but to themselves. Whilst an

intimate knowing of the woman was considered important, the independent midwives made no mention to creating openness, however it could be contested that they had to be open to acknowledge their bodily and emotionally felt sensations. Their use of the term “knowing” appears to relate to the knowledge that is revealed however this is not completely clear as “arising as” appears to relate to a means of perception.

Davis Floyd and David (1997, p.156) further asserted that their bodily felt intuition would also be linked to their “spirit and psyche”. These sensations however would not be described as organic or changeable or emotionally felt and the accounts are somewhat vague without any description of what is meant by ‘spirit’ or ‘psyche’.

Ólafsdóttir (2009), in her qualitative, narrative study of birth stories from twenty Icelandic midwives, was the only other associated research found to associate midwives’ ways of knowing as ‘spiritual’. The narratives of the Icelandic midwives described their practice knowing as related to a “spiritual nature even transcendent” (Ólafsdóttir 2009, p.i). The midwives however denied their knowing was linked to psychic sensitivity and associated it to a perception through God:

“The midwives drew attention to the fact that they were not psychic but maybe sensitive or perceptive to people and their surroundings believing in a higher power like God”.

This could be construed as a form of spiritual knowing and the transcendence or intuitive knowing through means of a ‘spiritual guide’ was related as contact with other spirits:

“Some of the midwives reported that women or other transcendent people had told them or described to them who was behind them from the other side possibly a named doctor or midwife”

(Ólafsdóttir 2009, p143).

It is acknowledged that intuitive knowing through transcendence has been identified by the midwives in Ólafsdóttir's (2009) study. This could be construed as similar to findings within the independent midwives experiences when on one occasion, one of the midwives described an abstract image that provided a means of knowing through guidance during labour. The midwives in Ólafsdóttir's (2009) study however narrated this generally as 'guides' who were present during their practice , however the midwife in this study described particular details of an abstract figure and the specific information it relayed concerning guidance during a woman's expulsive stage. The similarity between the two descriptions was that a number of midwives in both cohorts expressed these occurrences occurred in a “matter of fact way”, on other occasions however, some of the midwives in Ólafsdóttir's (2009, p. 142) study related to them as “crazy experiences”.

The independent midwives in this study similarly perceived intuitive knowing through a series of figurative and non-figurative images. The images were described as seeing unusual wildlife, predicting the sex of babies and angelic and other non-specific images. Both these abstract and specific images were conceived by the independent midwives as omens. Apart from the prediction of babies' sex, these images were believed to herald good or poor outcomes for women's prospective births. For example, a vision of something unusual in nature on the way to a home birth indicated that all would go well. For the midwife who visualised angelic presences, she identified that they would herald both bad and good outcomes. If the midwife visualised a darker shape this would generally mean a poor outcome,

however if it appeared as a lighter blue colour this would represent where the woman would give birth. The idea of an intuitive form of knowing through the reception of images being an omen has not been previously described in the research concerning intuition. This is also an area that may lead to debate and concern if midwives are using omens to guide their practice. The independent midwives, however, would intuitively notice this and concurrently increase their vigilance rather than act on an image or an omen directly.

It could be construed that the visualisation of an image could be compared with mysticism previously refuted by Benner (1984) as being not associated with intuition, as she maintained that intuition is only available in situations where a deep background of the situation exists. This assertion was in keeping with the independent midwives' experiences, as they juxtaposed their intuition with situational knowledge and an intimate knowing of the woman, so it is possible that this side of the phenomenon offers more knowledge to the concept of intuition. Paley, however, (1996, p. 664) highlights that those accessing mystical intuition do not deny Benner's assertion by stating:

“serious mystics (as opposed to dabblers) would also claim that they require a deep background understanding, so this point does not get us very far”.

It is acknowledged and accepted in this study that the midwives used situational knowledge and an intimate knowing which could be considered Benner's (1984) notion of “deep background knowledge” alongside their intuition. The reception of abstract or specific images whilst not recognised by mainstream empirical science has however been identified in previous research (Ólafsdóttir 2006).

Whilst Ólafsdóttir's (2009) study was the only associated literature found to comparatively analyse intuitive knowing through abstract or specific images, it has been acknowledged however that the homebirth midwives in Davis-Floyd and Davis' (1994) study mentioned a spiritual psychic link, albeit vaguely, to their intuition. In this study, this side of the phenomenon was limited to two of the independent midwives' experiences which may account for the dearth of literature in this area. It is also relevant to consider that the majority of the scholarship surrounding intuition is derived from nursing researchers and theorists, the only two studies concerning midwifery intuition (Davis Floyd and David 1997; Ólafsdóttir 2009) have both illuminated a spiritual or psychic facet of intuitive knowing, so it remains a salient element of the phenomenon.

Another further means of the independent midwives' process of knowing was through the perception of a dream. In this example it should be made clear that intuition is not necessarily connected with dreaming, however the dream the independent midwife experienced offered her information which enabled her to be vigilant to a situation in practice. There was no other literature that could be traced to this side of the phenomenon and once again it appears to be a rare and possibly new side of intuition in midwifery practice.

A further means of knowing, the independent midwives identified, was through their own emotions. Polkinghorne (2004, p.110) concurs with the notion of emotion as intuitive knowing and asserts that it provides an ethical dimension for "right actions". Polkinghorne (2004) attests that emotion can focus attention to reveal aspects of a situation that may otherwise remain hidden. The midwives' emotional felt noticing concurred with this as their intuition enabled the discernment of specific knowledge. This could also on some occasions reveal vague or tacit knowledge that something

was not right. Similarly, Ólafsdóttir (2009) discovered that development of inner knowing was often related to emotional situations. Ólafsdóttir (2009, p.201) reported that the Icelandic midwives' emotions could:

“support or restrict development of knowledge depending on the context”.

The independent midwives only related however that emotionally felt sensations enabled their intuitive knowledge. It also appeared that whilst some experiences appeared to be linked to emotional situations, this only became apparent after the noticing had occurred. The knowing appeared to predict, for example, a poor outcome, however when initially sensed it was not linked to an emotional situation.

It is construed that vague or specific or directional noticing through a physical or emotional feeling could be compared to the concept of embodied knowing. The nature of the independent midwives' embodied noticing can be compared to the philosopher and psychotherapist, Gendlin's (1970) notion of bodily felt meaning. Gendlin (1970, p. 561) asserts that human activity and experience is not a result of conscious thought but stems from felt meaning:

“there is also a powerful *felt* dimension of experience that is prelogical, and that functions importantly in what we think, what we perceive, and how we behave.”

He does however distinguish between the notion of bodily understanding and reflective verbal thought. Polkinghorne (2004, p. 140) similarly makes this differentiation, however utilises the term “embodied knowing” which he asserts:

“functions below the level of conscious awareness and is more carried out in reflection.”

Polkinghorne (2004, p. 140) attributes embodied knowing to:

“emotions, memories, spatial and temporal locations, the felt presence of other people and things and language”.

which appears in part to concur with Gendlin’s notion of felt meaning. The midwives’ embodied responses were frequently experienced as emotional sensing and were commonly described as perceiving a feeling. An intimate understanding of women was also key to some of the midwives’ emotionally felt noticing. A specific directional message could provide knowledge of for example, a woman’s emotional state. This would enhance the midwife’s ability to empathically sense the woman’s needs. This would concur with Polkinhorne’s (2004) notion of emotion and felt presence. Gendlin (1974) similarly emphasised that felt meaning is differentiated from simply emotion by its characteristic of multiplicity. He maintained that it was a complexity of circumstances and personal aspects. This complexity in terms of personal aspects was apparent in the midwives’ experiences and was evidenced by the interrelation of bodily felt and emotionally felt sensations. For some midwives direct emotion or a sense of *anxiety* would be experienced concurrently with bodily-felt noticing. Similarly, on other occasions embodied knowing was juxtaposed with the reception of behavioural cues. This illuminates the complex nature of intuitive noticing and could be seen as confirming Gendlin’s (1974) notion of the complexity of bodily felt meaning.

The independent midwives’ bodily sensations were sometimes felt in a specific and defined area; however on other occasions they would simply be described as instinctive. Whilst Gendlin (1974) and Polkinghorne (2004) do not limit their concept of embodied knowing to specific parts of the body, the term ‘bodily felt’ and ‘embodied’ is interchangeably utilised to depict their theories and its inherent complexities. In the midwives’ experiences different means of perception could be

experienced interchangeably. This again illuminates the complexity of intuition underpinning Gendlin's (1970) notion of bodily felt meaning.

This study has illuminated a range of intuitive knowing which assist in the comprehension of intuition and enables it to be more tangible: through the reception of cues, specific bodily felt and emotionally felt sensations, as well as the reception of a dream and images. This appears to create a new dimension of the phenomenon, intuitive knowing, however it is acknowledged that bodily felt sensations in the form of "gut instinct" (Davis Floyd and Davis 1996; Barker 2011) and the reception of guiding images (Ólafsdóttir 2006) have been previously described.

Having discussed the means or process of the independent midwives' knowing, the intuitive knowledge it revealed will now be analysed. The vague, specific and directional knowledge revealed by the midwives' intuitive noticing has similarly given the phenomenon more clarity and range and identified the definition of intuitive knowledge (see figure 5:4, p. 238). The vague typology of the midwives' experiences could be comparable to various theories and conceptual understanding of tacit knowledge with the consideration that it is not easily determinable (Polanyi 1966; Benner 1984; Johns 1998; Toom 2012). The vague knowledge it illuminated, for example, that something was not quite right, was echoed by the nurses in Benner's (1984) seminal study.

Whilst elements of the independent midwives' knowledge remained vague or tacit, their descriptions of '*specific or directional noticing*' have described a more tangible level of knowledge. Kinds of specific and directional noticing through the reception of cues for example, whilst it was evident that some kind of cue was being received

it was not always specific enough to be described as verbal or non-verbal. This elucidates that the midwives' knowing could be on occasion tacit even though the knowledge was specific or directional. This was illuminated when the midwives' intuition revealed specific information such as the prediction of a post-partum haemorrhage; however the cues that illuminated this knowledge were somewhat tacit. Often these occurrences would occur when empirical evidence was indicating the opposite. This indicates that the reception of cues may possibly occur before clinical signs manifest. Such tacit knowing that is nevertheless, directional, if disseminated and recognised could provide the practitioner with time to consider any necessary action before the emergency occurs.

The information revealed to the independent midwives belies the concept that intuition is limited to tacit knowledge (Benner 1984; Johns 1998). This is evidenced by the content of knowledge that it provided for the midwives. As well as the prediction of a post-partum haemorrhage, this included the realisation that women's labours were obstructed before clinical signs manifested, actions during women's expulsive stage and information on whether or not to care for a woman.

It was however evident that whilst the knowledge was always either specific or directional such as the direction of a clinical intervention during labour, the independent midwives were not always clear exactly how this had occurred. Eleanor for example (section 4.2.2.3.1, p.138) could describe that she had observed specific noticing through bodily cues that a woman's pelvis looked *congested* which was subsequently linked to the woman's labour becoming obstructed. Eleanor did not however immediately link the congestion with obstruction, or define what she meant by "congestion", this only occurred on further reflection.

This also questions the definitional status of specific or directional knowledge and to what extent this knowledge remains in the tacit domain. For example directional knowledge necessitated an action; however the underpinning knowledge or rationale for why this was occurring was not always clarified or evident. This directional form of intuition associates the concept of knowledge with action. This notion of knowledge as action is linked to Toom's (2012) assertion and Argyris and Schön's (1974) seminal work on theories of action. Argyris and Schön's (1974) scholarship has roots in the theories of the unconscious asserted by Freud and Jung and their work has centred on examining conscious and unconscious reasoning processes. Their theories are underpinned by the concept that individuals are designers of their own actions. Argyris and Schön (1974) propose two kinds of theories of action. Firstly *theories-in-use* or operational theories of action, which they explicate as tacit knowledge that is evident in a person's actions; these differ from their explicit or *espoused theories* that individuals use to describe and justify behaviour. They further assert that few people are aware that the theory or 'map' they use to take action are not the theories they explicitly espouse.

Argyris and Schön's (1974) theory was evident within the midwives' experiences, for example, with Polly and her specific noticing through a bodily sensation when she received a message through her hands. Polly's espoused theory expressed how she balanced her intuition with her scientific knowledge to make clinical decisions (section 4.2.2.5, p.164). However, when making a decision in her described scenario she prioritised her ethical knowing over her scientific knowledge or intuition, in this case, adhering to the couples' wishes.

This also illuminates how other forms of knowledge are utilised alongside intuition. It did, apart from Polly's example, appear however, that on the majority of occasions

that the independent midwives' espoused theories of action appeared to be directly linked to their operational actions. In the midwives' experiences, the operational theory of action was associated with their use of specific and directional knowledge. The map or theory of action would arise from their intuitive noticing and they would then act directly to ameliorate this situation by suggesting, for example, that the woman could change her position. Argyris (1982) has asserted that the effectiveness of individuals' actions results from developing congruence between theories-in-use and espoused theory. From the midwives' described actions, this would appear already accomplished suggesting the effectiveness of utilising intuition as a form of authoritative knowledge.

In the associated literature concerning practice knowledge van Manen (1990) similarly debates whether action, or in the independent midwives' experiences, the direction of a specific course of action, can be considered *knowledge*. van Manen (1990) expressed this notion by advocating that tacit knowledge is difficult to elucidate due to its embodiment in skills that are located within practices or the way an individual carries out something. He utilises the distinction between technical knowledge which can be articulated and practical knowledge which is learned experientially and expressed only in actions. Van Manen (1990) maintains that the explication of tacit knowledge is virtually impossible due to the complex individual situations that occur in a professional's lived experience. This questions whether the independent midwives' experiences of intuition revealed intrinsic knowledge or merely the direction of a course of action without the underpinning reasoning. This is exemplified by the various directional examples within the midwives' experiences: such as the need to stay with a woman either in hospital or within the close locality, the immediate need for a caesarean or guidance during an emergency birth procedure. These do appear to entail a command for action rather than actual

knowledge. However specific information such as the prediction of a post-partum haemorrhage or obstructed labour; or eliciting a woman's needs such as physical support or a change of position during labour; or the need for emotional support could be construed as *diagnostic knowledge* as the independent midwives' intuitive knowledge is not simply borne out or elucidated by their actions. This does appear to offer another perspective from previous theories of intuitive knowledge.

This discussion has illuminated how the findings of the study explicated the constituent term of '*noticing*' which has explored *the relationship between* intuitive knowing as a process and the content of knowledge and *the specific nature of* intuitive knowing and the content of knowledge. It has presented how the study has illuminated the salient differences between intuitive knowing and knowledge which in the main, lacked clarity in the literature. A range of knowing and knowledge has been more specifically described and this section has analysed the relevance of this alongside the existing scholarship of intuition and presented the insights this study has discovered. Both the embodied nature of intuition and the reception of images have been given more detailed descriptions, providing more clarity to the phenomenon. Similarly, the independent midwives' intuitive own emotions have been more explicitly expressed. The reception of cues and dreams appeared to present a new side of the phenomenon which provides a further dimension of intuition.

The tacit nature of the information revealed has also been discussed and whether this should be considered as knowledge or action. It has been debated however that this study has illuminated a form of diagnostic knowledge as well as directional knowledge which appears to clarify further an element of the phenomenon intuition.

It was evident within the findings and the previous section that intuitive knowing and noticing was not always the only factor the midwives would utilise; many other elements could be present. This concurs with Polkinghorne's (2004, p.151) assertion that practice always takes place alongside practitioners' "background understandings" and "personal and social context", which illuminates how intuition cannot be limited to the midwives' only form of practice knowing but forms part of a complex milieu of practice knowledge and its utilisation. This leads on to the next area of discussion which analyses this complexity and how other forms of knowledge are utilised and prioritised alongside intuition when acting in practice. An analysis of relevant literature and the contribution it provides to the scholarship concerning intuition will now be presented.

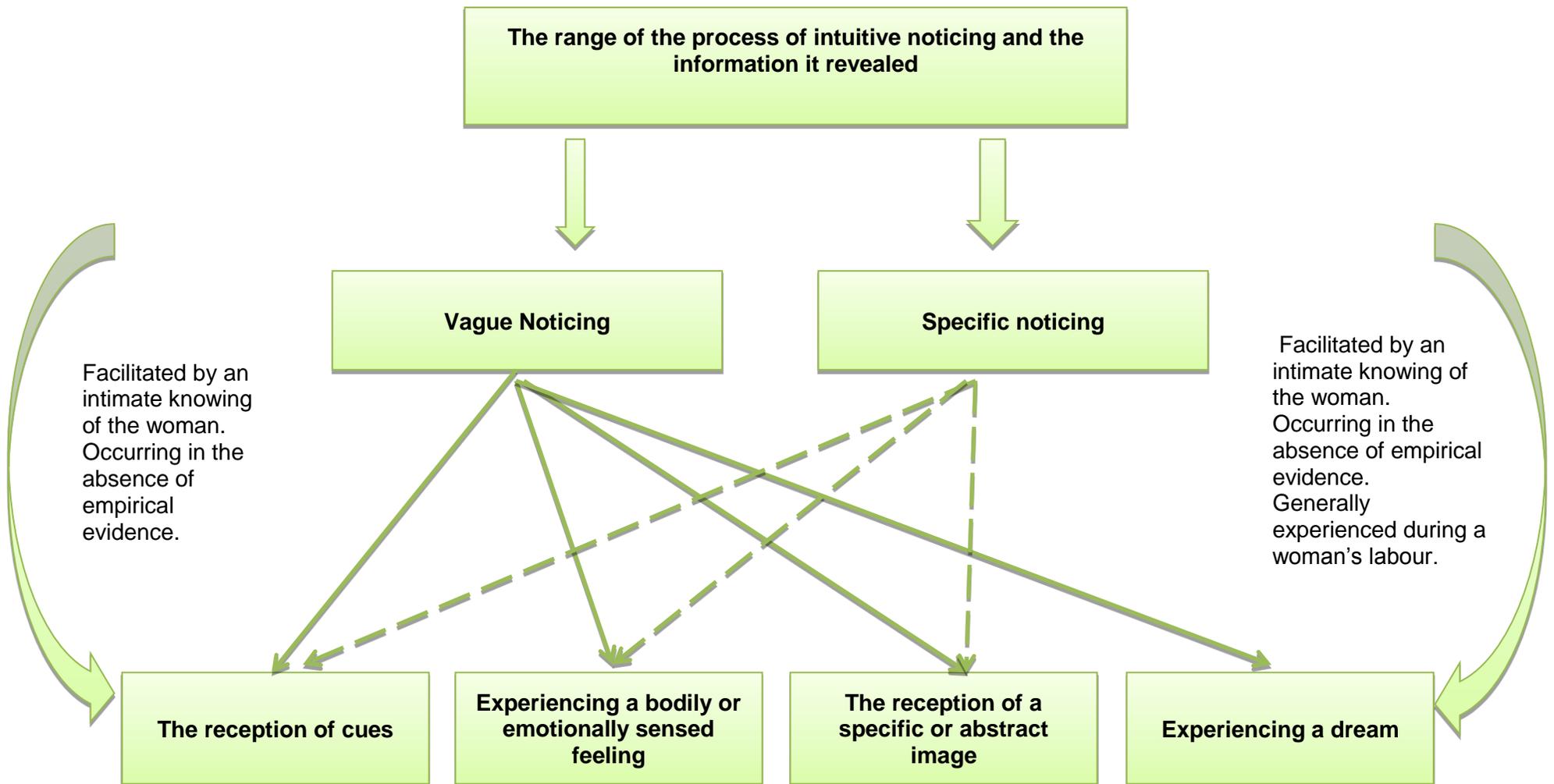


Figure 5:1: The range of the process of intuitive noticing and the information it revealed

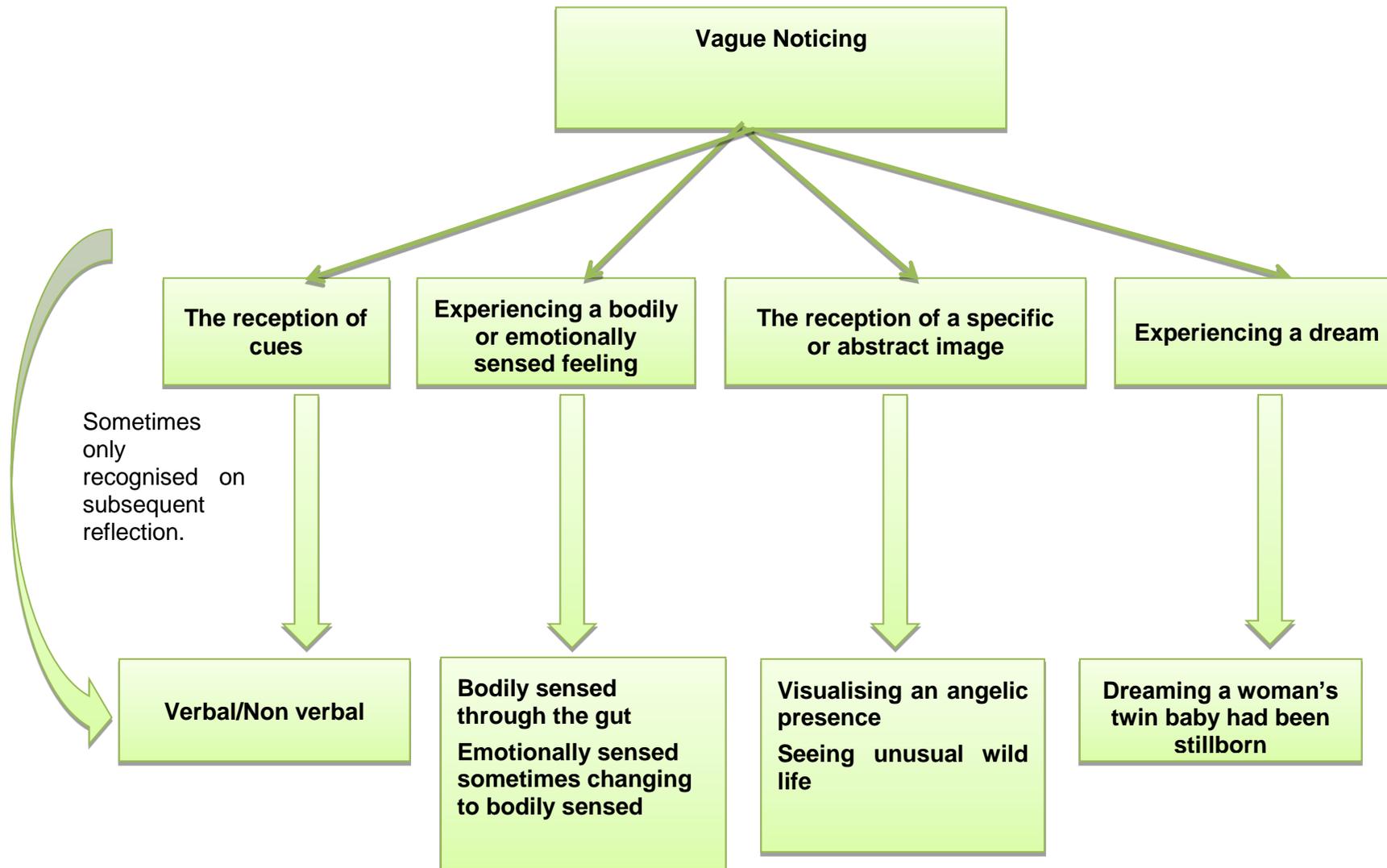


Figure 5:2: Vague Noticing

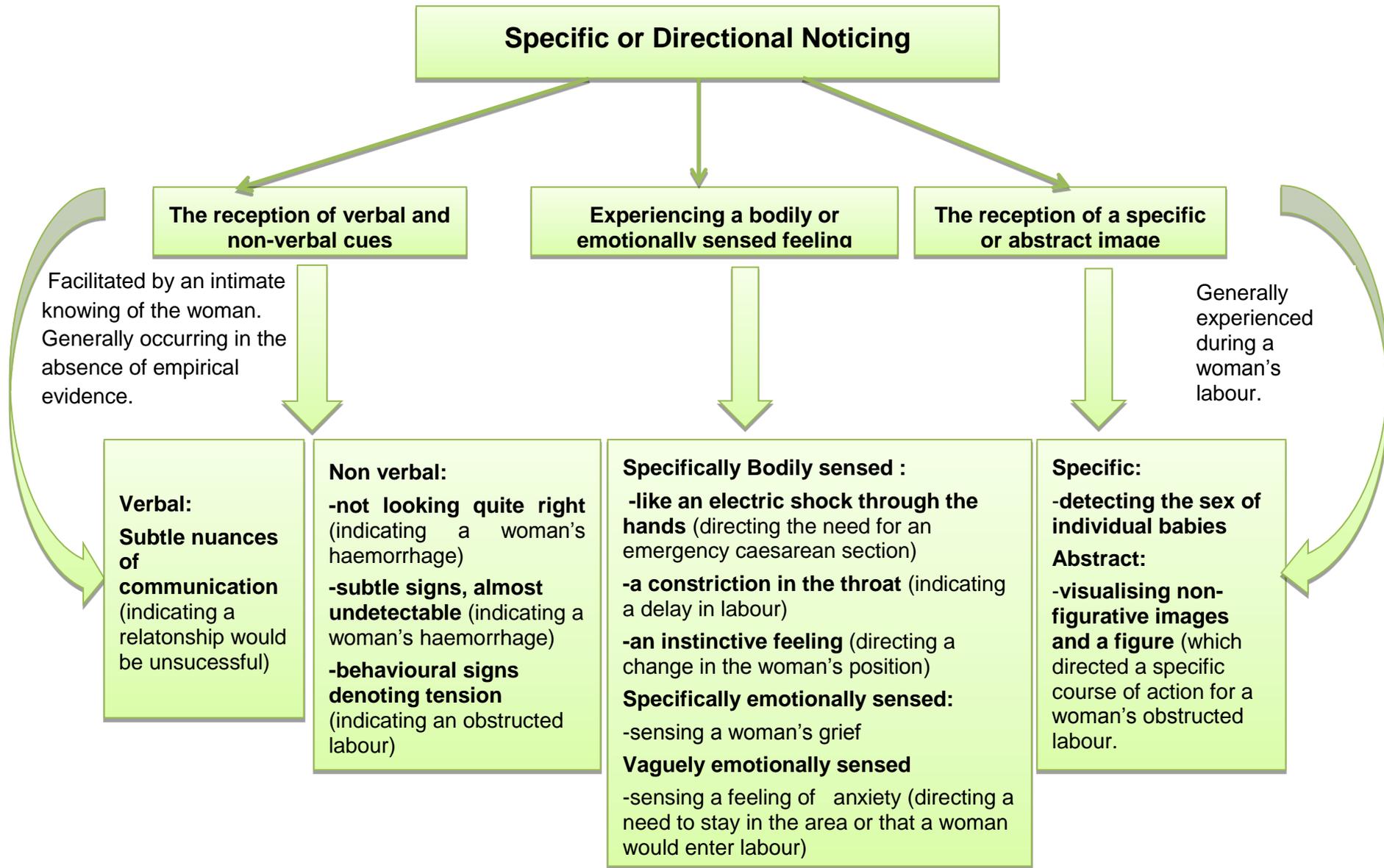


Figure 5:3: Specific or directional noticing

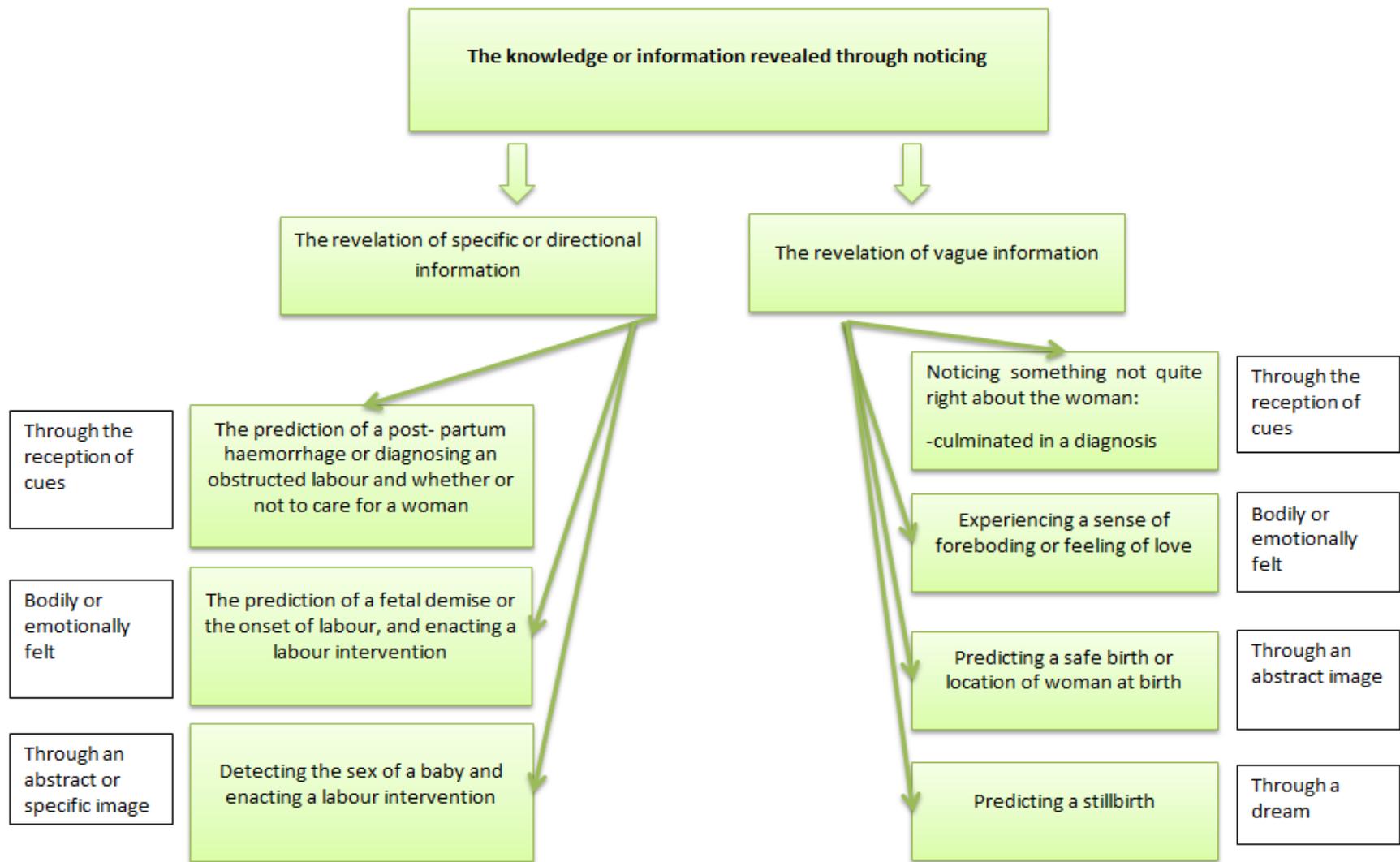


Figure 5:4: The knowledge or information revealed through noticing

5.2.2 The prioritisation and complexity of intuition and other forms of knowledge when acting in practice and the implications for scholarship

Within the findings, the complexity of using intuition within practice as an authoritative form of knowledge revealed how intuition could be prioritised seemingly independently but that it could also be juxtaposed with other factors and forms of knowledge (see figure 5:5, entitled '*the juxtaposition of other forms of knowledge in practice*' p. 260).

One of the challenges of a phenomenological study is explicating the phenomenon in the lifeworld. This has already been partly demonstrated in the previous section when considering the difference between the process of the independent midwives' intuitive noticing and the information it revealed. Towards this endeavour whilst it is useful to separate the midwives' other forms of knowledge in order to explore in more depth the *separate* parts of the phenomenon, in the spirit of phenomenology it was also imperative to recognise their interrelationship with intuition. This relates to Gendlin's (1991, p.25) concepts of phenomena being "implicitly inter-crossed" or having a "pre-separated multiplicity". Gendlin (1991, p.27) asserts that it is an incorrect assumption to believe the nature of experience can be reduced to simple factors and laments that the dominant worldview supports this premise:

"Foremost is the assumption that order can only be something *imposed on* experience, that forms, distinctions, rules or patterns are the only order so that there is nothing else, no "other," and hence no possible interplay between the forms and something more."

It is therefore important to express how within this study the midwives' intuition did not exist alone within their lifeworlds but was interwoven with other factors and forms of knowledge. This is clearly articulated by Polkinghorne (2004, p.156) in his discussion of the context of human situations:

“The background has a web like, holistic organization that connects and integrates its vast network of pre-theoretical knowledge about how to do things. Thus, we do not experience objects in the world as bits and pieces, but as contextualised interconnections.”

To establish the depth of the phenomenon it is also however necessary to emphasise the distinctiveness of intuition and illuminate the role intuition played in these other forms of knowledge which will now be explicated.

Within the findings it was recognised that the independent midwives juxtaposed their use of noticing with other factors when utilising their intuition. These included the midwives' scientific or theoretical knowledge, practice constraints, knowledge of the practice situation or situational knowledge, an intimate knowing of the woman, the midwives' ethical knowing or views and the woman's and partner's wishes. Contributing to the complexity of the midwives' utilisation of intuition is the issue that on some occasions the midwives described that they seemingly utilised their intuitive noticing independently without recourse to other forms of knowing. These particular contextual factors have been selected as they were the most frequently occurring events within the midwives' descriptions and contribute a different perspective towards the available academic literature on intuition. Further complexity encompasses how exactly their intuitive noticing was actually utilised and whether the type of noticing or the juxtaposition of other factors or types of knowledge affected its utilisation or prioritisation.

One such area of complexity was the independent midwives' use of situational knowledge alongside their intuition. In this discussion the concept of situational knowledge and its associated terminology, including situational awareness (Benner 1984; Fore and Sculli 2013), a sense of salience (Benner et al. 2010) and reflective understanding (Polkinghorne 2004) will be defined and explored. In the spirit of phenomenology lifeworld examples from the midwives' experiences will then be analysed alongside existing research and literature. It is however acknowledged there is a dearth of research and literature in this area so this discussion is somewhat challenging. This has however illuminated that this is an area for further research.

It is first necessary to define what is meant by *situational knowledge*. Knowledge of an individual practice situation has been coined by nursing theorists as 'situational awareness' (Benner 1984; Fore and Sculli 2013). A review of the literature undertaken by Fore and Sculli (2013) resulted in the identification of three general characteristics being associated with situational awareness: *perception*: entailing the perception of the elements in the environment in a volume of time and space, *comprehension*: comprising the comprehension of their meaning, and *projection*: including the projection of their status in the near future. All of these three elements however were not always discovered in the independent midwives' lifeworld descriptions. Whilst the midwives' intuitive noticing could be related to *perception*, and it was often evident that they understood or *comprehended* the relevance of their situational knowledge, the *projection* of this knowledge however, was not described or evident. To ensure clarity and faithful representation of the midwives' experiences the term situational knowledge has been more closely defined by Benner (1984) as a comprehension of the practice situation. This definition appears to more accurately reflect the midwives' descriptions of this phenomenon. Benner

(1984, p.84) in her early seminal study investigating intuition in nurses relates to situational knowledge and asserts that:

“capturing the descriptions of expert performance is difficult because the expert operates from a deep understanding of the total situation”.

On occasions the midwives would utilise their intuition alongside their specific clinical knowledge. Benner (2010, p83) advocates that situational knowledge should be utilised alongside “the ability to use knowledge from a rich knowledge base.” This appears to connect situational knowledge with intuition however Benner (1984) seemed more concerned with the inability to identify intuition rather than its juxtaposition with situational knowledge. Benner and colleagues (2010, p.83) however in a later research project moved from intuition to the term “sense of salience” and “situated cognition”. In a research review of nurse education Benner et al. (2010, p. 83) criticised nursing education for being dominated by abstract or “decontextualized knowledge” and calls for a move:

“from a focus on covering decontextualized knowledge to an emphasis on teaching for a sense of salience, situated cognition and action in particular situations.”

Benner et al. (2010) describe this as knowing what is important and unimportant about a clinical situation. The term “sense of salience” appears to resonate with Polkinhorne’s (2004, p. 176) concept of “reflective understanding” where the practitioner is:

“attuned to the salient features of a specific situation and responsive to the nuanced changes that are occurring during an interchange”.

Benner et al. (2010 p.83) attest that situated cognition or a sense of salience requires “linking discernment and perception”. It was clear that the independent

midwives utilised their intuitive knowledge with their situated knowledge to enable discernment or judgment in a practice situation and responded to the “nuanced changes” (Polkinghorne 2004, p. 176). Examples of this would occur in the midwives’ experiences where they would utilise their situational knowledge which would comprise knowledge of the woman’s background, alongside their intuitive noticing. They would then empathically sense the woman’s needs and provide personalised sensitive care. They did not however explicitly describe however a ‘sense of salience’.

The utilisation of intuition, juxtaposed to situational knowledge, could be compared to Polkinghorne’s (2004, p. 140) concept of “reflective understanding” in terms of how the independent midwives would respond to the changes in the woman. They would utilise both situational and intuitive knowledge, sensing the woman’s needs, and enact their discernment or judgement to provide the appropriate care. Polkinghorne (2004, p. 171) further defines reflective understanding in the following way:

“Reflective understanding draws on the full human capacity for interacting with other persons. It involves an integration of previous personal and cultural learning of imagined scenarios of responses to an action, and of emotional reading of possible actions in the situation”.

In the midwives’ experiences they would relate both to their own emotionally sensed intuition and the woman’s emotions including the felt presence of for example, the woman’s bereavement or exhaustion, concurring with Polkinghorne’s (2004) concepts of interaction and emotional reading. The midwives would directly act with a provision of care and their utilisation was juxtaposed by reflective understanding or situational knowledge. The midwives’ use of intuition in this sense concurs with Benner et al.’s (2010) theory of situated cognition and Polkinghorne’s (2004) notion

of reflective understanding and demonstrates the multifactorial nature of their intuition and its utilisation.

On other occasions there is evidence that the independent midwives juxtaposed their intuition with clinical situational knowledge evidenced by words such as 'given the whole picture'. It is interesting to note in the midwives' experiences intuition juxtaposed to situational knowledge could take priority over professional historical knowledge, and discernment or a judgment would then result in a direct action to enact an intervention such as monitoring a baby's heartbeat. On other occasions, the midwives would prioritise their scientific knowledge; however this would create tension when their intuitive knowledge was later confirmed as correct and their scientific knowledge was disconfirmed.

There were a number of occasions when the independent midwives were faced with similar multifaceted situations when their intuition was non-specific and their utilisation of their intuition was used to increase vigilance in a situation. On these occasions, they appeared to be searching for more situational knowledge to strengthen their intuition. This could occur when they experienced a bodily sensed of foreboding concerning women's pregnancy and labours. This concurs with Polkinghorne's (2004, p.176) notion of reflective understanding where practitioners enact a decision process that "adapts to the nuanced changes in which practitioners serve". The midwives' decision processes enabled them to be vigilant for further clinical situational knowledge to strengthen their intuition.

What appears to resonate in this study when compared to the literature is the independent midwives' descriptions of how they utilise situational knowledge to support their intuition. This occurred when their intuitive noticing was both specific

and non-specific. The experiences were however associated with Polkinghorne's (2004) theory of reflective understanding in terms of their emotional reading of a situation and adapting to nuanced changes within a situation. They were similarly supported by Benner et al.'s (2010) sense of salience as the midwives showed evidence of being attuned to the salient features of a situation as they were juxtaposing their intuition with situational knowledge whether it was knowledge of a woman's previous history or the overall clinical picture. The midwives did not however explicitly describe a personal sense of salience.

In terms of explicating the phenomena in the independent midwives' lifeworlds it is necessary to consider how their intuition interrelated with their situational knowledge. In the midwives' examples of *specific* noticing the situational knowledge appeared to enhance their intuition as a holistic process so they could utilise it with confidence. In the midwives' experiences of *unspecific* noticing however, they were seeking situational knowledge to underpin and strengthen their intuition. It could be construed that the situational knowledge enabled specific rather than unspecific noticing and therefore the ability to utilise their intuition however, it is acknowledged however that this is only conjecture. It must also be recognised that the midwives' utilisation of their intuition was also governed by other forms of knowing, namely, ethical knowing and an intimate knowing of the woman.

Within Polkinghorne's (2004, p.171) theory of reflective understanding his notion of "emotional reading" and adapting was apparent in a two dimensional sense in the independent midwives' experiences. Firstly, from the aspect of intuition being emotionally felt, and secondly by their ethical judgement and their consideration of the women's wishes and intuition. This introduces another form of knowledge that

was utilised with, and on occasion prioritised over, intuition: the midwives' ethical knowledge and judgments.

Whether their intuitive noticing was vague or specific or supported by situational knowledge, or informed by previous experience, the independent midwives could on occasion prioritise their ethical knowledge to support the woman's agency. This demonstrates how they ethically valued the woman's decision making. It could be mooted that this ethical component within their decision making was heightened either because of their close intimate connection with the woman or the humanised way in which they were accustomed to work in an independent model of practice.

It is acknowledged that on other occasions that the independent midwives' intimate knowledge of the woman could similarly not be excluded. This would occur when the midwives would seemingly utilise solely their intuition, particularly during labour. It is noted however, that this would generally occur during emergency situation which required an immediate decision and action. An additional factor also to consider is that consent during emergency procedures presents communication difficulties. These examples demonstrate that although at times the midwives' ethical knowing was concerned with promoting the woman's agency, on other occasions they acted immediately to promote the woman's and baby's safety. This demonstrates the range of the midwives' ethical knowing and its situational context and highlights an important element that was illuminated during the study which concerns how at different times, the midwives would prioritise different forms of knowledge. If, for example, the care episode occurred during the woman's pregnancy, the midwives would prioritise the woman's decision making, or their ethical knowing, alongside their intuitive and situational knowledge. On other occasions other forms of knowledge would be prioritised. If, for example, care was

given during a woman's labour, the midwives' would seemingly prioritise their specific and directional intuition. This appears to suggest that during labour intuition is prioritised over experiential and ethical knowing, however although not explicitly mentioned by the midwives, situational knowledge and an intimate knowing of the woman cannot be excluded as being integral to their judgment.

On other occasions, if the independent midwives' intuition was vague, they would prioritise situational knowledge to create a clearer picture for decision making; or would delay decision making and increase monitoring and vigilance in their care. This is despite there being no impending clinical signs or symptoms that there was anything wrong. This demonstrates how on this and other occasions the midwives would prioritise their intuition and their situational knowledge over their clinical knowledge. This prioritisation of knowledge demonstrates how flexibly the midwives would utilise their intuition and other forms of knowledge and would not prioritise one form of knowing over another. They would, however, individually assess a clinical situation and utilise their knowledge appropriately.

When comparing the independent midwives' experiences of ethical knowing with the literature concerning ethics in care, a number of theorists have analysed the concept of ethical knowing (Taylor et al. 2011; Carper 1978). Taylor et al. (2011, p.85) propose the following elements are essential for ethical or moral knowing: "sensibility", "responsiveness", "reasoning" or "discernment", "accountability" and "valuing". Taylor et al. (2011) conceive "sensibility" as recognising a moral moment in the 'patient's' narrative. This was evident in the independent midwives' experiences and tended to occur when they would recommend a particular course of action underpinned by their intuitive noticing, however on occasion, the woman would decline their recommendation. This generally occurred in the midwives'

experiences when perceiving vague noticing that all was not right. On these occasions they would increase their alertness and vigilance in care provision, and on occasion recommend that women should be transferred to hospital. Unfortunately however, women could subsequently decline the independent midwives' endorsements. Tragically, in these cases the women's babies could be stillborn. The midwives' ethical knowledge would enable them to enact *sensibility* by recognising the moral moment when the woman declined their recommendation for example, to transfer to hospital.

Taylor et al. (2011) describe their second tenet of ethical knowing, "responsiveness", as the willingness and associated action to respond to the moral moment. This was evidenced in the independent midwives' experiences by their willingness to respect the woman's wishes. On these occasions, the midwives would utilise knowledge of their historical professional experience with their intuition, however their ethical knowing and judgment would be prioritised over other forms of knowledge. The midwives' prioritisation of knowledge similarly resonates with Polkinghorne's (2004) notion of reflective understanding concerning situational knowledge. This is exemplified by their utilisation of both "previous personal learning" and "emotional reading" of possible actions in the situation, knowing that although their noticing and experience recommended a specific course of action they would adhere to the woman's wishes by not transferring her to hospital (Polkinghorne 2004, p. 171).

Taylor et al.'s (2011, p. 85) third tenet of ethical knowing concerning "accountability" or accepting responsibility for their ethical decisions was similarly evidenced by the independent midwives' experiences. It was however evident that this was challenging especially when their intuition was confirmed as being correct which

also encompasses the other tenet of Taylor et al's (2001) ethical knowing: "valuing" or integrity. Whilst the midwives realised their intuition was correct, evidenced by their actions of encouraging the woman to transfer to hospital and the subsequent confirmation of their intuition when babies were stillborn; they possessed the integrity of ethically knowing they had to adhere to the woman's wishes despite their views to the contrary. The midwives clearly described their equally challenging sense of accountability and it is poignant to note that in one of the midwife's experiences, her pain of loss and accountability was similar to the woman's loss of her baby.

The independent midwives would however similarly recognise the woman's personal ethical dilemma in these situations which is not specifically mentioned in Taylor et al's (2011) work and could possibly be connected to their intimate connection with the woman. This evidences the challenges experienced by the midwives when their intuition was confirmed as being correct.

It was also apparent that as well as the use of their ethical knowing the independent midwives would juxtapose their situational knowledge with their utilisation of their intuition. It is however noteworthy that despite their intuition, knowledge of their historical professional experience and situational knowledge, on these occasions their ethical knowledge was prioritised.

Carper's (1978) seminal work on patterns of knowing in nursing included an ethical component. Carper's (1978, p.9) fundamental pattern of ethical knowing focused on "matters of obligation" or what "ought to be done". Similarly, to the independent midwives' examples, Carper (1978, p.9) acknowledges that moral dilemmas occur in health care and emphasises the complexity these situations present:

“Moral dilemmas arise in situations of ambiguity and uncertainty when the consequences of one’s actions are difficult to predict and traditional principles and ethical codes offer no help or seem to result in contradiction”.

The midwives would however make clear ethical judgment based on the woman’s wishes substantiating Carper’s (1978, p.9) assertion that moral choices must be considered in terms of specific actions (in this case supporting the woman’s choice) and taken in “concrete situations”. It is acknowledged however that the midwives rarely had *concrete* practice situations and had to frequently act against their clinical judgement in order to support the woman’s wishes. Carper’s (1978) concept of ethical knowing has been however criticised as lacking definition and detail (Porter 2010). Mitchell (1999, p. 34) focuses the concept of ethical knowing more specifically and maintains that practitioners’ ethical knowledge should:

“ honour the client’s meanings, realities, possibilities, wishes and choices”.

This assertion certainly reflected the midwives’ sense of ethical knowing as they upheld the women’s wishes and choices and prioritised their ethical knowing.

MacLellan (2014, p. 806) explores ethical knowing in her feminist discourse of midwifery ethics, similarly providing more detail:

“An Ethic of Care is required that encourages reflection and education of caring feelings to ascertain the best moral course. It addresses issues arising from relations between the unequal and the dependent, such as a woman in labour and her midwife.”

The independent midwives certainly prioritised the women when making decisions in labour and similarly showed evidence of reflection of how to determine the most moral judgment.

On other occasions, women would follow the recommendations of the midwife however a choice to opt out of their recommendation would always be provided even if it was against the recommendations of the hospital staff and their own intuition. Once again it is pertinent to emphasise how the midwives will only make a decision underpinned by their own ethical code or sense of ethical knowing to support the couple's actions. This is further reinforced by the way the midwives made decisions collectively between themselves and the prospective parents. This is evidential of the effect the midwives' intimate connection has upon utilising their ethical knowing.

The independent midwives' ethical knowing in terms of supporting women's wishes has been demonstrated as taking priority on some occasions over their intuitive and knowledge of their historical professional experience. Whilst key aspects of their ethical knowing resonate with theories of ethical knowledge it is noteworthy that the woman's wishes would be prioritised over the safety of the mother and baby presenting within itself an ethical dilemma. In the UK, however, the legal position concerning women's autonomy and consent are absolute, as Birthrights (2014 p.4) assert:

“The experience of giving birth will not affect whether you have capacity to consent to treatment, except in very exceptional circumstances where capacity is completely destroyed by drugs, fatigue, pain or anxiety”

This tenet was strengthened by a court case involving *S v St George's Healthcare Trust* in 1998 (Harvey and Marston 2000). The Court of Appeal considered the case of a woman who refused a caesarean section for pre-eclampsia: the court's ruling was unequivocal:

“while pregnancy increases the personal responsibilities of a woman, it does not diminish her entitlement to decide whether or not to undergo medical

treatment. Although human, and protected by the law in a number of different ways ... an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.”

(Harvey and Marston 2000, p. 384).

Within the recently published “Code” (NMC 2015, p.4), section 4.1.1, clearly states that nurses and midwives should:

“balance the need to act in the best interests of people at all times with the requirement to respect a person’s right to accept or refuse treatment”.

From these excerpts it is clear that the independent midwives adhered to the guidelines within their own professional body’s code and legal requirements, as they clearly presented the information and risks to the women enabling them to make fully informed decisions. This demonstrates their accountability albeit at times in challenging circumstances heralding tragic outcomes. This adherence to professional guidance and legal statute could also be considered as contributing to the midwives’ ethical knowing.

The independent midwives’ use of their ethical knowing or prioritisation of the women’s wishes has been explored. It has been demonstrated that making the extremely difficult decision to support the women’s wishes tended to be when their noticing was vague or if it was perceived by a dream. Despite having intuitive, and on occasions, situational knowledge, the midwives would prioritise the woman’s decision making. It has been highlighted how their accountability for these actions is supported by legal statute and their professional code and additionally contributes to

their ethical knowing. It does however illuminate the complexity of utilising both intuition and other forms of practice knowledge to make clinical decisions. This may have been further associated with their close connection with the women in their care which was also integral to their utilisation of their intuition and introduces the next area of knowledge with which the midwives underpinned their intuitive noticing: the midwives' intimate knowing of the woman.

The findings demonstrated that the independent midwives' intuition was enhanced by an intimate knowledge of the woman as previously explicated in section 5.1.5 (p.214); this was especially evident during the reception of cues from women. Whilst an intimate knowing did not form a separate constituent, as it is considered contextual rather than fundamental to the phenomenon, it was intrinsic to the context of the midwives' descriptions and so warrants further elaboration and discussion. It was acknowledged by the midwives the time independent practice afforded the intimate knowing of women and this concomitantly enabled the reception of verbal and non-verbal cues and other forms of intuitive noticing.

The findings consistently demonstrated the juxtaposition of the independent midwives' knowledge of the women with their intuition. This illuminates how interrelated this form of knowing is throughout the midwives' experiences and integral to both the '*how*' and the '*what*' of the midwives' intuition. This intimate connection with the woman provided the midwives with a "relational way of understanding" (Todres 2008, p. 1568) or knowing the woman. This is a way of knowing that is related to the lifeworld and concerned with relationships and connection. It establishes a concrete relationship between the midwife and the woman "as part of a living situation" (Todres 2008, p. 1568). The literature surrounding the midwife-mother relationship has consistently reported how this

relationship is an essential element to midwifery care however this study has illuminated how this specifically enhanced the independent midwives' intuitive knowing.

The midwife-mother relationship has been seen as the lynch pin of maternity care provision (Walsh 1999; Kirkham 2000; Hunter 2006). Central to an intimate connection and sustainable relationship with the woman appears to be sharing ideologies (Kirkham 2000; Barker 2011). The independent midwives would consistently demonstrate a willingness to share ideologies by placing the woman at the centre of their care which was centred on their ethical principles. The continuity of care the midwives provided afforded this intimate knowing, however it appeared not just the continuity but the time spent that enhanced this connection. It also illuminated the social aspect of the midwives' care which in turn enhanced their intimate knowing.

It is acknowledged that many midwifery researchers and theorists have identified the central importance of an intimate connection between the midwife and mother (Walsh 1999, Kirkham et al. 2002; Hunter 2006; McCourt and Stevens 2009). Hunter (2006) has identified from the woman's perspective that key components to developing and maintaining this relationship are mutuality and intimacy. The independent midwives clearly identified how the intimate connection is linked to finding shared interest or mutuality with the woman which in turn enhances their intuition through the reception of cues, for example, during women's' labours. This intimate knowing was pivotal to all the midwives and their experiences have highlighted how this could enhance their intuition.

The independent midwives' intimate knowing of the woman similarly resonates with Mok and Stevens' (2005, p.30) and Ólafsdóttir's (2009, p. 192) assertions who both

describe intuition within midwifery practice as the notion of connectedness; an “awareness creating relationship” or “tuning in” to the woman. Both protagonists were unable to state exactly how this would occur apart from acknowledging the necessity of a relationship. It is notable however that an intimate knowledge of the woman was such a vital component within the midwives’ experiences that on occasion, intuition was absent when care was provided to a woman who was unknown. This infers that it is an intimate connection of the woman which enables the reception of cues which in turn reveals the intuitive knowledge. This clearly identifies that there are factors which enhance the midwives’ intuition such as an intimate knowing of the woman and similarly factors that deplete it such as the foreign environment of the hospital.

Winter (2002), similarly, in her grounded theory study of UK independent midwives’ practices of assessing labour found that if a woman was transferred to hospital the midwives’ intuitive sense was diminished. Bone (2009) has asserted that this could be ascribed to the belief that intuitive knowing is not valued in the hospital settings where medical science and technology are revered. It should be acknowledged however that the midwives in Winter’s (2002) study would have known the women before transfer occurred. Ólafsdóttir (2009) concurred that the Icelandic midwives’ inner knowing would be enhanced by a connection between the midwife and the woman. It was unclear however in Ólafsdóttir’s (2009) study as to whether this connection was built over a period of time, or was created during labour care. What was apparent however was that the Icelandic midwives acknowledged that their intuition could be disabled when “working as a machine using protocols” Ólafsdóttir’s (2009, p192). This appears to concur with Bone’s (2009) and Winter’s (2002) findings.

This highlights the question of whether intuition is dependent on the individual's capacity for perceiving it, or the situational context of the event. To debate this point two examples from the descriptions are utilised when the independent midwives experienced a disabling of their intuition. This occurred with Fiona, for example, when she felt her lack of intimate knowledge of the woman and working in a hospital environment disabled her intuition. This meant she failed to intuitively perceive cues of an impending post-partum haemorrhage until clinical signs were present. It could be said her individual capacity of perceiving intuition was disabled as she had no intimate knowledge of the woman, however, similarly the foreign hospital environment may have influenced the situational context of the event. Another example is highlighted by Dee whose intuition was disabled when she lacked historical professional experience of care during a woman's labour whose baby was presenting by the breech. It could be considered that her individual capacity was disabled by a lack of historical professional experience and the anxiety this provoked. It could also, however, be considered that the care requisite for the baby's breech presentation was part of the situational context of the event. It appears that from these two situations that both capacity and context are necessary factors in the perception of intuition.

It is apparent that the continuity of care the independent midwives experienced aided their intuition by providing an intimate knowing of the women they cared for which concomitantly enhanced their reception of cues. This adds to the well-researched benefits of continuity of care (Sandall et al. 2013). The lack of intuitive noticing could on occasion in the midwives' experiences however possibly be attributed to the hospital environment where this occurred.

The reception of verbal and non-verbal cues and the experience of a bodily or emotionally felt sensation, were immersed in the unique context of the independent midwifery which enabled not only an intimate understanding of the woman however also illuminated the vulnerable status of their practice. On a number of occasions however specific noticing was experienced when first meeting a woman. The decision of whether or not to book a woman could determine a successful or negative relationship. A negative relationship could possibly lead to litigation or being reported to their professional body. This would appear unique to the context of this study however utilising intuition to assess a potential relationship with a woman could be potentially useful particularly when a practitioner or student has a choice in whether to work with a woman and her family. It is acknowledged however this is rare within the maternity models of care NHS; this element is considered in more depth in the implications for practice (see section 5.3, p.273).

On other occasions however, the independent midwives would seemingly act solely on their intuition apparently without consideration of situational or ethical knowledge, once again demonstrating the complexity of utilising intuition. It must however be acknowledged that as all the midwives had an intimate connection with the woman they cared for due to the context of the care their independent practice afforded, this cannot be discounted. This introduces the next area for discussion: utilisation of intuition without recourse to other forms of knowing.

The occasions when the independent midwives would seemingly simplistically utilise intuition without aforethought concur with Davis Floyd and Davis' (1994) findings which reported that the midwives from the USA would fully rely solely on their intuition and negate any rational or other thought processes. On a number of occasions it was notable that the midwives in this study would act immediately

without hesitation. This tended to be, but not exclusively, through the course of a woman's labour during her expulsive phase: a time when informed consent is challenging and their actions could be lifesaving. On occasion this would occur seemingly when it was against their usual paradigm of practice. It is significant to emphasise that during pregnancy women are fully able to give informed consent, the feasibility of achieving informed choice when women are in labour and especially during women's expulsive stages however would be extremely difficult.

This further illustrates the complexity of utilisation, the independent midwives would seemingly act immediately after their specific intuitive noticing during women's expulsive stage of labour as there was little opportunity to utilise their ethical views to enable informed consent. Whilst Davis Floyd and Davis (1994) have discussed that midwives would utilise their intuition as a primary authoritative source of knowledge to underpin their practice it is not specified as to whether this would differentiate with the woman's views, whether they were in labour or whether informed choice was utilised.

It remains difficult to ascertain however as to whether the independent midwives' experiences of seemingly utilising intuition independently included other forms of knowing such as the use of situational or experiential knowledge. Whilst this was not overtly expressed, on subsequent reflection when the midwives were considering their practice they could justify their actions in terms of their knowledge of anatomy and physiology. It could be proposed that this would have therefore included use of scientific situational knowledge or even experiential knowledge. In terms of explicating the phenomenon, it appears increasingly difficult to clearly explicate the parts of the phenomena as these often interrelate with each other. This

concur with Polkinghorne's (2004, p.156) philosophical concept of what he terms 'the situated focus of the background':

"The background provides understandings that enable a person to decide what actions to take from a range of possibilities and places practices within the context of a situation"

He further suggests that this is not always evident to the practitioner:

"Background knowledge configures itself according to specific contextual or situational needs; it does not bring to the fore the totality of all that it holds"

Similarly, their intimate knowledge of the woman cannot be discounted as by the very nature of their independent status, continuity of care would enhance a close connection with the woman. The midwives in the study however had the freedom to utilise their judgement and individualise their decision making. This was not without careful consideration of how they used their intuition which introduces the next part of the discussion concerning how the midwives would develop and reflect on their intuition and the outcome of events. This will explore further this complexity and will examine the findings concerning how intuitive knowledge can be developed to improve future practice.

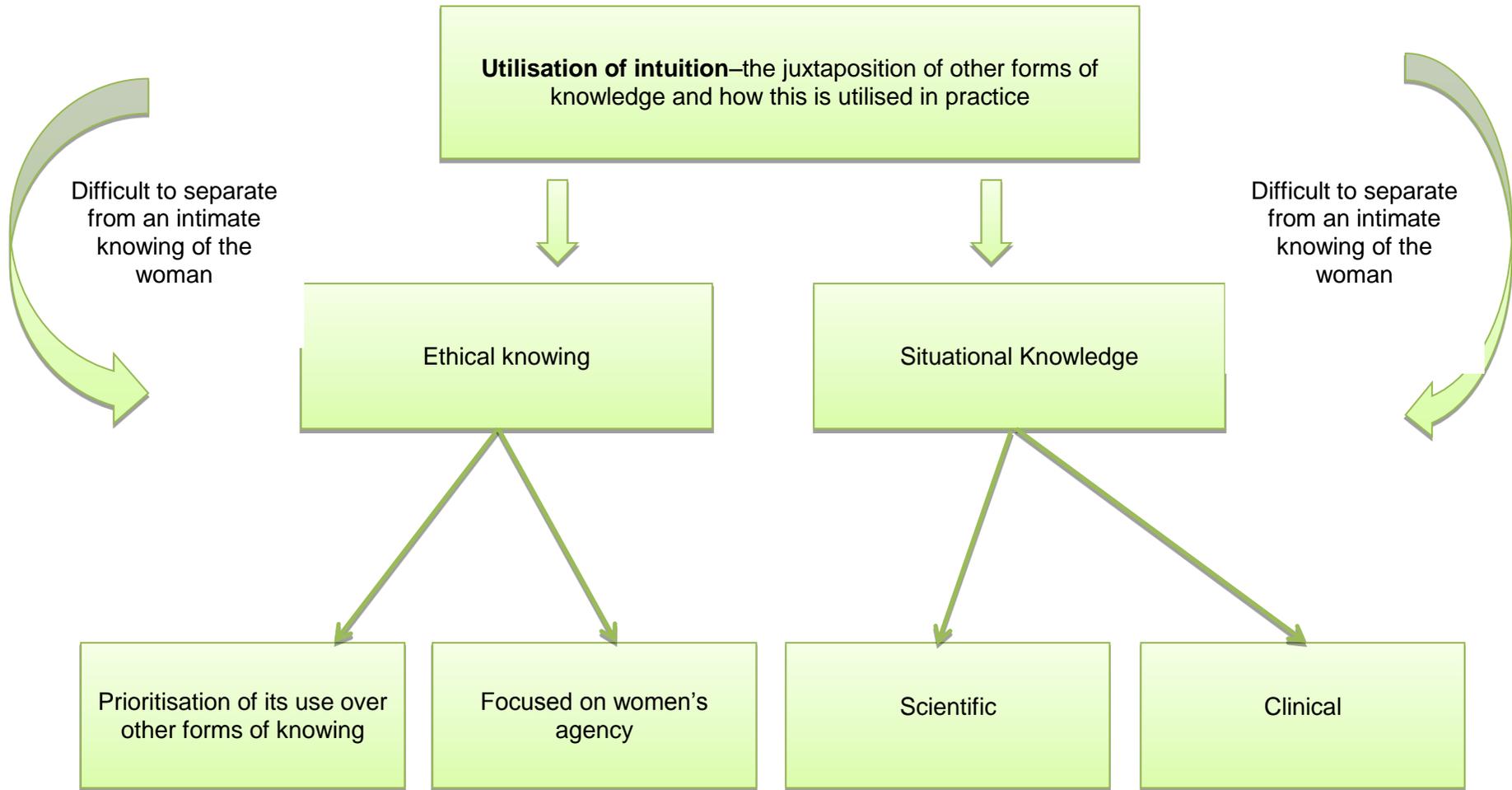


Figure 5:5: The juxtaposition of other forms of knowledge in practice

5.2.3 How intuition can be further developed through a process of reflection and the implications for scholarship

Whilst the scholarship concerning reflection on and in practice has identified how tacit knowledge and intuition can be identified, this study not only clarified exactly how this was done: through a process of confirmation and disconfirmation (see figure 5:6, p. 270 entitled '*How intuition is utilised to hone and develop practice knowledge*'). It also identified how the independent midwives would further develop and hone their intuition and practice knowledge. This demonstrated that the midwives' intuition and associated practice knowledge evolved dynamically.

Polkinghorne (2004, p.257) has asserted that practice knowledge and judgment does not just comprise "expressing unconscious or internalised background knowledge" or "subsidiary awareness", he advocates that it is vital to combine this knowledge with a notion of "reflective understanding". This notion was certainly illuminated within the independent midwives' experiences. Their descriptions narrated how they would not only utilise their intuitive noticing juxtaposed to other forms of knowing, their practice knowledge was constantly organic due to their reflection. This reflection would be focused on their actions after their intuitive noticing. Following a practice incident where the midwives had experienced intuition, they would reflect upon it and consider how they had perceived their knowledge and whether any other factors had been present. They would also acknowledge any tension between their intuitive noticing and other forms of knowledge. Polkinghorne (2004, p. 171) has asserted that:

"Actions in judgment practice at the most basic level are valid if they move

the caring process forward. The validity process cannot be known in advance. Validity is determined by its effectiveness in a particular situation at a particular time”

Whilst Polkinghorne is referring to actions in practice the concept of *validity* can be transferable to the midwives’ experiences of *confirmation* of their experiences. This concept was also evident in the midwives’ experiences as they would “move” their personal practice “forward” through a process of reflection on their intuitive noticing and the outcome of events to enable the *validity* of their actions (Polkinghorne 2004, p. 171). This occurred on a number of occasions in the midwives’ experiences.

Confirmation enabled the independent midwives to trust their intuition as an authoritative form of knowledge. Jordan (1993) has asserted that for knowledge to be authoritative it needs to motivate decisions and actions. This was not to say that intuition was the central tenet in making clinical decisions. The midwives would reflect on the event and utilise their theoretical knowledge to substantiate their actions underpinned by their intuition.

Erlandson (2015, p.122) utilises the philosophical concepts of Merleau Ponty to illustrate the complexity of the lifeworld, which can be relevant also to the practice situation:

“through this conscious life are carried perceptual life, instincts and knowledge but also the past, future and the physical, ethical and ideological situation”.

The independent midwives through a process of reflection would not only consider the effectiveness of their intuitive noticing, however would examine their own experience, ethical knowing and scientific knowledge. This depth of reflection is

important for all practitioners for the accountability of their actions, however also to develop and examine their own knowledge and not just reflect on their actions which can be limiting (Erlandson 2015).

Jarvis (1992, p.178) has confirmed that reflective knowledge is a means of learning “new knowledge” from the experience which he asserts is “adding to the body of theory”. The independent midwives would reflectively analyse when their intuition had been confirmed how they could further utilise this knowledge in future practice events. This enabled the development of ‘new’ midwifery knowledge such as a diagnostic tool for the diagnosis of obstructed labour and the recognition of subtle non-verbal cues to detect a haemorrhage. Confirmation could at times demonstrate their intuition was more accurate than their scientific knowledge and taught valuable lessons about not ignoring it. For the midwives, this would bring empowerment that their intuition was correct. This would enable them to recognise their intuition as an authoritative form of knowledge. Similarly, Argyris and Schön (1974) assert that people hold maps in their heads about how to plan, implement and review their actions. They advocate that individuals design action in order to achieve intended consequences and monitor to learn if their actions are effective. This was evident in the midwives’ experiences as they would directly describe the process of review or reflection that enabled honing of their practice.

Johns (1997, p. 24) has maintained that:

“reflection enables the tacit to be made visible as reflexive knowledge”

He asserted that this improves practice knowledge as personal knowing is enhanced. This was reflected within the independent midwives’ experiences when reflection during the interview elucidated that their ways of intuitive knowing, for example through the reception of cues, could be identified. Confirmation that their

knowledge was correct would enhance their present and future practice by providing them with an enhanced practice knowledge base. This was especially evident when the midwives' noticing through the reception of non-verbal cues could specifically diagnose obstetric emergencies such as postpartum haemorrhage or an obstructed labour. Following confirmation this type of intuitive noticing could be utilised on other occasions as a diagnostic tool which both strengthened the authority of their intuitive noticing and enhanced their practice by its use. This demonstrates how the midwives' specific reflection on their practice enabled them to "move the caring process forward" (Polkinghorne 2004, p. 171). It could be suggested that this was for the individual independent midwives' practice and potentially for midwifery practice generally.

The independent midwives' experiences of reflection and ongoing confirmation of their actions relate in part to Benner's (1984) notion of patterning in terms of how having experienced this occurrence on a subsequent occasion this knowledge could be recalled. Benner (1984) asserted that intuition was a form of patterning or pattern recognition made up from previous practice experiences. She described that this entails the mental capacity to perform a rapid selection from alternatives without conscious awareness. Whilst Benner's (1984) notion of patterning was asserted to be tacit, or unconscious, the midwives however would consciously reflect on their experiences enabling their practice knowledge to be more readily comprehensible. It is also an example of how reflection can unleash the tacit reservoir of knowing (Johns 1998).

For some of the independent midwives, their lack of intuition was perceived as a result of a lack of experience. This would certainly concur with Benner's (1984) notion of patterning. Benner (1984, p.37) did however maintain that:

“highly skilled analytic ability is necessary for these situations with which the nurse has had no previous experience”

For the midwives, with their juxtaposition of other forms of knowing, Benner's (1984) assertion certainly resonated with their experiences. This discussion would also suggest that intuition does have a multifactorial dimension wherein certain qualities such as historical professional knowledge and an intimate knowledge of a woman are requisite for its functioning. On other occasions however it would appear to be absent without any apparent rationale, this did however enable the midwives to confer absolute authority to their authority and enabled them to be more balanced practitioners. These different facets of intuition provided the midwives with the understanding of their intuitive knowing and provided an arena where they can reflect and develop their intuitive knowing.

Todres et al. (2007, p. 36) use the term “empathic imagination”. This entails “dwelling” or reflecting with the complexities of a practice situation. The independent midwives described how through reflection on intuition or *dwelling* with the complexities of a practice situation they could make practice more comprehensible. Whilst this highlights personal reflection following their actions, Rolfe and Gardener (2005, p. 297) in their analysis of evidence based practice for nursing call for the

“on-the spot generation of reflective/reflexive evidence by nurses themselves as part of their everyday practice”.

Rolfe and Gardener (2005) assert that this would ameliorate the tendency for reflection and reflective practice to be marginalised by the hegemony of evidence based practice. This would appear to concur with Schön's (1983) notion of reflection *on* and *in* practice. Schön (1984) defined reflection *on* practice as a conscious exploration of past practice experiences by a process of analysis and interpretation. Whereas reflection *in* action was considered to be the conscious and mindful

attention to the practice situation as it occurs. Johns (1997, page 24) similarly described a reflective practitioner as:

“someone who views and responds to the world through a reflective lens”.

It is not clear within the independent midwives’ descriptions as to whether they were explicitly reflecting *in* practice or action. However a number of the midwives would consciously be aware that if their intuitive noticing revealed knowledge that had occurred in a previous practice situation, they would utilise this experience to hone their practice knowledge.

Rolfe and Gardener (2005, p.297) have juxtaposed the concept of reflection with the view that if reflection and reflexivity was introduced as an “everyday” form of practice this would give more credence to its use and provide greater range of practice knowledge. The independent midwives’ experiences of utilising intuition would commonly trigger reflection providing them with a more diverse form of practice knowledge.

The literature appears to concur that tacit or intuitive knowledge can be developed and honed through a process of reflection on and in practice through a process of reflexivity to increase personal knowing. What appears to be an insight from this study is the identification of how the independent midwives would engage in reflection after confirmation of their intuition occurred.

The other aspect involved in honing the independent midwives’ intuition was disconfirmation. Jarvis (1992) maintained that new ways of practicing are tried out as a result of reflecting upon why a performance has achieved or not achieved the result it has. Disconfirmation of the midwives’ intuitive knowledge was considered

'grounding' and enabled, like other forms of knowledge, the view that intuition could be wrong. It is noteworthy that on occasions reflection on disconfirmation of their intuition enabled the midwives to comprehend that their sense of intuition was actually a lack of confidence. This links to Johns' (1997) notion that reflection is linked to emotion. The midwives could seemingly elucidate the difference between feelings of unease, due to a lack of confidence, as opposed to an emotionally sensed form of intuitive noticing.

Disconfirmation could also occur when a lack of experience was present. Reflection on events enabled the independent midwives to realise that without previous experiential knowledge, intuition could be absent. Once again this would appear to make the midwives more balanced practitioners as they realised their intuition was not infallible. There could be a danger if any form of knowledge is considered absolute and prioritised above all others. This could be considered fundamentalism and mitigates away from individualised care.

The independent midwives' experiences of reflection on the disconfirmation of their intuition related to Jarvis' (1992, p.178) assertion concerning the process and result of learning from reflective practice:

"Professional performances will consistently be experimental and creative but this does not necessarily mean that they will be innovative, because reflective learning can demonstrate the validity of the procedure and the knowledge".

Jarvis' (1992, p. 178) assertion similarly resonates with Polkinhorne's (2004) notion of "validity" moving and developing practice. The midwives' experiences of disconfirmation demonstrated that on occasion their intuitive knowledge could be

invalid which enabled them to more fully comprehend their intuition and other sources of practice knowledge.

Whilst it was evident that the independent midwives' previous experiences were developed and reflectively honed throughout their careers both in the public and independent sector, this, however did not account for the visual images or dream that some of the midwives experienced described. In these cases a process of reflection did not enable full comprehension of intuition. What did occur however was that confirmation of practice enabled an increase in professional confidence. This notion of confidence generally occurred after the midwives had reflected on their experiences in practice and how specifically this affected their confidence in their intuition as a form of practice knowledge. This would empower the midwives to have the courage to utilise their intuitive knowing in future practice situations. It is also noteworthy that this knowledge was often not without regret that they had not acted more assertively at the time demonstrating how learning through reflection that occurred during the interview, involved an emotional and ethical component.

Whilst reflection theorists acknowledge that the reflective process includes own emotions (Johns 1994), the independent midwives' experiences also relate to Polkinhorne's (2004, p. 140) notion of embodied understanding which synthesised emotions and "felt presence". This certainly encompasses the midwives' intimate connection which relates to the notion of a "felt presence" and also includes elements of emotion, for example, a sense of regret for not acting on their intuition sooner. This however, also involves an ethical dimension demonstrating the complexity of intuition and how it is difficult to separate its elements.

On some occasions however, even though the midwives' intuitive knowledge had been confirmed as correct and their rational knowledge incorrect; they would not confer absolute authority to it. This once again illustrates the complexities of the independent midwives' utilisation of their intuition. In Davis-Floyd and Davis' (1994) study, however, the midwives would always confer authority to their intuition to the point that if events served to disconfirm their intuition, they would believe that their rationality had taken over. The independent midwives' views of their intuition however would appear more balanced and concur with Polkinghorne's (2004) sense of embodied understanding and Todres et al.'s concept of empathic imagination demonstrating the multifactorial nature of practice judgment.

The elaboration of the findings has illuminated a number of new insights to the salient elements of the phenomenon intuition, the complexity of its utilisation in practice and its dynamic capacity for change. These findings will now be synthesised in terms of their implications and recommendations for practice and education.

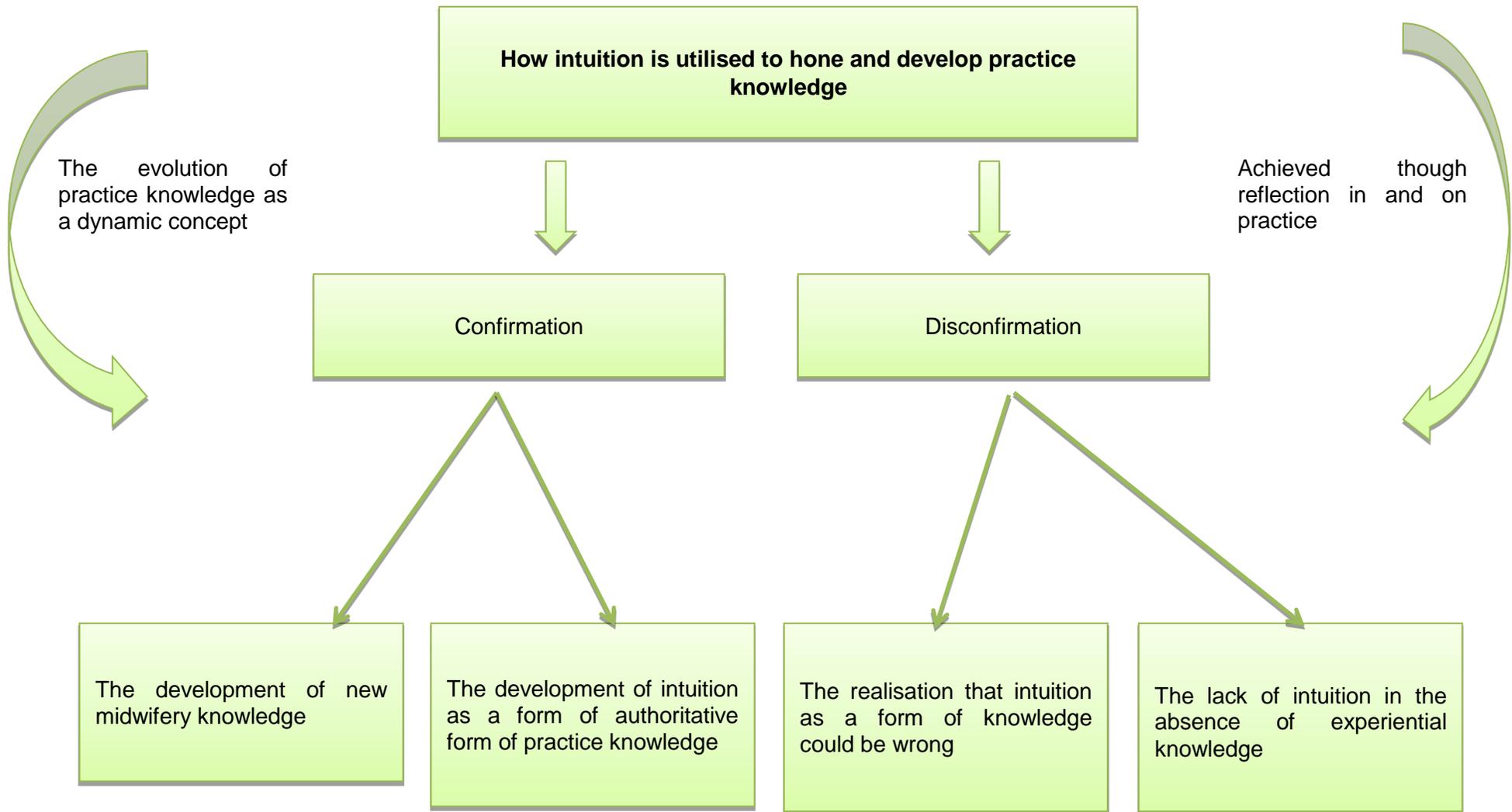


Figure 5:6: How intuition is utilised to hone and develop practice knowledge

5.3 Implications for practice and education

Having considered the implications for scholarship, the implications for practice and education will now be presented. This discussion will consider in turn each of the three sections just presented within the elaborations of the findings and has been summarised into a diagram (see figure 5:7, p.282). This section will commence with a discussion surrounding how the identification of salient elements of intuition can assist education and practice.

The range and differentiation of the independent midwives' intuitive noticing has transformed the concept of intuition from a tacit vague entity to a more concrete phenomenon. Intuition has already been hailed as an important form of knowledge (Wickham 1999; Davis-Floyd and Sargent 1997; Brown 2006). This more discreet, explicit definition of intuition will more easily enable its dissemination as an authoritative and integral form of practice knowledge to students, midwives and other health practitioners.

This study has further clarified the phenomenon of intuition by elaborating the range of both vague and specific noticing. Vague noticing occurred during all stages of the childbirth continuum, throughout women's pregnancy, labour and their post natal care whereas specific noticing, apart from on one occasion generally manifested during women's labours. It is not completely clear as to why specific noticing occurred almost exclusively during women's labours. It is suggested that care during labour requires the midwife to be vigilant at all times for changes that may occur. This could perhaps have heightened their noticing enabling it to be specific

rather than vague. This may have implications for practice in terms of creating discussion and enabling midwives to identify their own intuition during women's labours or at least encouraging a vigilant focus or 'noticing' during this time.

Within the identification of the independent midwives' intuitive noticing during labour, the midwives described how there were subtle signs that were almost undetectable that would occur before any clinical physiological signs manifested. This has important implications for practice as the recognition of these subtle signs could improve diagnostic care as these behavioural cues would for example, often herald an impending post-partum haemorrhage.

The observation of non-verbal cues could also involve the recognition of behavioural signs denoting tension which resulted in obstructed labour. Both these observations of non-verbal cues appear to offer a new form of midwifery knowledge which may be utilised to predict obstetric emergencies. It is recognised however that this form of diagnostic knowledge however should be subject to further investigation before any claims can be substantiated. This kind of practice knowledge or artistry may well be apparent in midwifery practice, albeit in a tacit form. A suggested recommendation is reflective practice sessions for novices and experienced midwives to elicit forms of intuitive noticing. The reception of cues is a tangible concept and could be enabled with novices, or further developed with more experienced midwives, through units of education that concern communication or reflective workshops. Reflective practice sessions could commence with a focus on diagnosing obstructed labour and post-partum haemorrhage through the reception of cues. This could lead to exploration other areas of midwifery practice recalling how exactly diagnoses of emergencies or other clinical decisions are made.

The reception of cues could be perceived verbally through subtle nuance of conversations and was generally concerned with revealing the information about whether or not the independent midwives should accept women into their care or determining if a woman needed an additional visit to check their wellbeing. This was particularly resonant with the independent midwives and the context of their practice. Working independently, and at times without insurance, made them vulnerable to litigation, thus communication and relationships with their clients were paramount. In terms of the implications for education and practice, whilst the majority of midwives that practice within the NHS do not have the luxury of choosing clients, the relationship between a midwife and woman she is caring for remains of the utmost importance (Hunter and Deery 2008). This type of intuition could be utilised to detect whether there may be possible difficulties within a relationship, or could highlight that the woman may need support of some kind. It could also be utilised in student midwives' caseloads. This is not to say however, that intuition should be the central criterion for selecting women. As with all practice knowledge, it should be juxtaposed with other factors. Student midwives, as a mandatory part of their pre-registration education, have to care for a caseload of women (NMC 2009). This is an educational practice initiative where students learn to care for women and provide continuity of care throughout the childbirth continuum. During this initiative they have the opportunity to work with indirect supervision from their mentors. To some extent the students do have options of who they care for, as caseloads tend to be small, so utilising this form of intuition prior to booking women could be helpful to enable an intimate connection and provide a catalyst for developing intuition with women. When a connection is not present, however, it is essential for the student to analyse why this is so and similarly learn from this experience.

Central to student caseloading should however be the woman's choice. One of the most important facets of the caseloading scheme is that consent is gained from the woman. This is undertaken by the mentor after the woman has met the student and when the student is not present. All women have to give consent to the student caseloading scheme and it is suggested it could be based upon a mutual connection between the woman and the student.

Another facet of vague and specific noticing was experiencing a bodily or emotionally sensed feeling. The concept of a bodily sensed feeling has been discussed in the literature before in terms of the phrase 'gut feeling' or 'gut reaction'. The study has however described this bodily sensed feeling with greater detail and clarity. The independent midwives, on occasions, would experience their visceral feelings as either within the gut, as previously described, (Benner 1984; Davis-Floyd and Davis 1997) however, they would also describe the sensation more specifically as a stomach ache or a feeling of nausea. Emotionally sensed intuition would generally be rather vague in description, namely that they felt 'something', generally a feeling of foreboding, however, on one occasion it was described more specifically as a feeling of love within the room. It has been recognised that models of reflection frequently include how an individual 'feels' within or after a practice event (Herbert 2015). The study's specific identification of bodily felt and emotionally felt sensations could aid students and practitioners to explore and reflect on their own embodied feelings more profoundly in order to develop or recognise their own intuition. This form of reflection would however have to be more explorative than the current models of reflection that do not necessarily reflect specifically on embodied reactions.

Whilst it has been acknowledged that the literature has already described experiencing a general instinct or feeling of anxiety or something not quite right about a clinical situation, (Rischel et al. 2007) as forms of intuitive knowledge, other examples described by the independent midwives in this study are far more specific. For example, an electric shock through the hands or a constriction within the throat. It is suggested that midwives working outside independent practice may be used to feeling a sense of anxiety but not the more specific types of bodily sensed feelings. This once again could be an area for future research to explore whether this type of intuition can or does occur outside independent practice. It also provides an area for consideration in the education of students and midwives. Such research could explore specific embodied responses to clinical situations and how they are individually perceived.

The other facet of noticing was the reception of a specific or abstract image or a dream. Once again this side of the phenomenon was experienced by the minority of the independent midwives and could be considered as mysticism or an element of spiritualism, hailing the same arguments as previously presented. There is a dearth of literature considering whether other midwives in the NHS ever experience these aspects of the phenomenon. In terms of dissemination and implications for practice it could certainly provide a spring board for discussion. It is however acknowledged that practitioners may find the reception of cues or bodily felt reactions, for example easier to accept and recognise from their own practice.

There is the risk that presentation of this more abstract side of the phenomenon may be ridiculed by other professionals or academics within the field; however there is no evidence to refute that others may experience these images or dreams as evidenced in part by the findings of Ólafsdóttir's (2009) research. Some of these

may appear foreign to midwives practicing outside independent models. They are however aspects of the phenomenon and cannot be dismissed. This could be an area for further research. Workshops exploring the rarer aspects of intuition may explicate areas of this side of the phenomenon. Reflective workshops could similarly be utilised to explore embodied forms of intuitive sensing such as bodily and emotionally felt intuitive perception. The concept of “mindfulness” or “being attentive to and aware of what is taking place in the present” (Brown and Ryan 2003; p.822) has been asserted as assisting individuals to become “alive” to the moment and consciously aware or attuned to their internal processes and states (Dane 2011). Mindfulness workshops could aid recognition of students’ and midwives’ intuition as they have been associated with intuition as the following excerpt details:

“By attuning individuals to phenomena arising through non-conscious operations, mindfulness may enable individuals to notice more of their intuitions”

(Dane 2011; p. 1008).

This process could be incorporated into reflective workshops.

It is also important to recognise the new forms of knowledge described by the independent midwives and ensure they are recorded and disseminated. This is also relevant when considering intuitive knowledge experienced by midwives within the NHS. It has already been identified that whilst midwives that practice within the auspices of the NHS utilise intuition, its discreet use remains covert (Scammell and Stewart 2014). Unless intuition is acknowledged and recorded this situation will remain and this form of artistry will remain hidden. To achieve recognition of intuition, it is asserted that these forms of intuitive knowledge could be included within record keeping. For example, documenting that a woman’s pelvis appeared “congested” or that she appeared tense or lacked a sense of wellbeing is an

example of how intuition can be recorded and could help ameliorate the absence of intuitive knowledge within practice. If the reception of cues became a recognised diagnostic tool, it may be possible to explore and document other aspects of the phenomenon such as embodied intuition. Once again reflective workshops exploring intuition in terms of personal experience, reflection and recording could aid this process, commencing with an exploration of *what is* recorded in terms of intuitive knowledge and illuminating *what is not*. This could further explore the other types of practice knowledge utilised and how and whether they are recorded.

The second area of the findings for consideration of the implications for practice and education concerns the prioritisation and complexity of intuition. The utilisation of other forms of knowledge demonstrates the complexities of using both intuition and other forms of knowledge in practice for clinical decision making. It also highlights that intuition is not generally utilised on its own but within a complex milieu of other forms of knowledge.

It could be considered that the context of the care on occasions was prioritised over the independent midwives' capacity for intuition and other forms of knowledge. In terms of the implications for practice, an intimate knowing of the women would appear to enhance the midwives' reception of cues. This form of intuition is, however, still relevant in models of care where midwives practice without the benefits continuity affords.

It is recommended that the provision of reflective workshops exploring intuition include the context of how intuition is explored and how sources of knowledge are prioritised to aid clinical decision making. It is necessary for midwives and allied health practitioners to comprehend the complexities of practice knowledge and learn

when it is appropriate to prioritise different forms of practice knowledge. This can only be achieved if models of care exist that empower both the women and their health care providers. Continuity of care models have demonstrated not only benefits for the woman but would enable practitioners to facilitate individualised care.

The individual capacity for experiencing intuition varies and can be contextual. The provision of reflective workshops should therefore include what enables and disables or blocks intuition. It is necessary for students, midwives and allied health practitioners to comprehend the complexities of practice knowledge and learn when it is appropriate to prioritise different forms of practice knowledge and to recognise and reflect upon tensions between different forms of knowledge. This can only be achieved if models of care exist that empower both the women and their health care providers. Continuity of care models have demonstrated not only benefits for the woman but would enable practitioners to facilitate individualised care. Integral to the independent midwives' intuition was an intimate knowing of the woman; this similarly underpinned other forms of knowing, including their situational knowledge and ethical knowing. If an intimate connection between women and midwives is so fundamental, this has implications for practice. Models of maternity care that promote continuity are recommended to facilitate not just intuition but also to enhance other forms of practice knowledge.

It is acknowledged that all midwives will be accustomed to utilising their clinical, ethical, scientific and situational knowledge however, what may be missing is the integration of their intuitive knowledge. Students' and practitioners' senses of intuition could be construed in terms of how they feel in a situation, whether they are subtly receiving or noticing the reception of cues. Once this is recognised it is

important to consider how they can explore and utilise this knowledge alongside their customary practice knowledge within their own area of work. This could be achieved through the facilitation of reflective workshops which explore not only intuition but other forms of knowledge that enable effective women-centred decision making. It is also important to consider how different forms of knowledge are utilised in different contexts.

A further recommendation is the development of guidelines that enable the flexibility for individualised care and individual clinical, ethical, authoritative decision making. There is a tendency within the NHS to standardise care in the quest for improved quality and litigation issues. This is supposed to be in the context of professional judgment, however because this move has led to the standardisation of guidelines and clinical pathways, this has resulted in a suppression of individual judgment. The danger of this standardisation is the maxim that one size does not fit all. Standardisation reduces the possibility of flexible individualised care and could be considered reductionist. Guidelines can also inhibit intuition and clinical decision making and do not necessarily promote the intimate knowing of the woman and *ethical* care. It has been recognised that decision making for women and midwives is based on: “complex human, contextual and other factors” (Noseworthy et al. 2013, p. 42) which reflects the findings of this study. The NHS, however, prioritises the use of evidence based practice. It is therefore recommended that guidelines that promote individualised care and embrace the complexities of practice knowledge are developed. This will serve to avoid a linear approach where midwives are prevented from incorporating all their forms of knowledge and only enabled to utilise one dimension of care. Basing practice on purely evidenced based guidelines can have a dehumanising effect (Johns 1995), whereas the independent midwives combined their knowledge including intuition to provide sensitive, individualised

care. The introduction of more fluid individualised guidelines could enable more holistic decision making improving care for women and providing accountability and autonomy for the practitioner.

The final area for consideration from the findings is how intuition can be further developed through a process of reflection. Receiving and reflecting upon confirmation and disconfirmation of their intuitive knowledge enabled the midwives to develop and utilise intuition as an authoritative form of practice knowledge. This presents intuition as a first person form of rational knowledge that can be tested and honed for future practice. This has implications for practice as it aids not only the understanding of intuition, but also provides a vehicle for its exploration and development.

Reflective workshops have previously been discussed a number of times; however their importance is again emphasised. The process of both confirmation and disconfirmation is an important tool to consider during workshops as it enables the freedom of not always being right. It similarly demonstrates the importance of utilising other forms of knowledge alongside intuition. This provides the opportunity for in depth exploration of both confirmed and disconfirmed experiences. These could provide a rich tapestry to underpin students' and midwives' practice and decision making. The importance of dissemination of new knowledge discovered through this process of reflection has already been discussed. It is recognised that practice, however, needs to allow, recognise and value the importance of reflection to develop individual practitioners. The crucial element for this to be enabled is the provision of time for this event. Whilst reflective workshops are ideal, Clinical supervision could also be a vehicle for this to occur. Similarly, another opportunity could be achieved through the process of revalidation which is a requisite,

mandatory part of midwifery and allied health professionals registration. This new initiative requires that every midwife, nurse and health visitor completes:

“Five written reflective accounts that explain what you learnt from your CPD activity and/or feedback and/or an event or experience in your practice, how you changed or improved your work as a result”

(NMC 2016, p.8)

The important element however is to ensure that practitioners do not solely focus on their actions as “knowing” is not the same as “doing” (Erlandson 2015, p.122) and to elicit intuition and other forms of practice knowledge requires a deeper level of reflection which examines all elements of a practice situation. This study has illuminated the complexity of utilising different forms of knowledge in a practice situation and how all forms need to be considered including knowing of the woman and her wishes. Therefore, for practitioners to focus on their actions solely, could be considered to be reductionist and self-limiting.

A number of implications and recommendations for practice have been presented. These recommendations have the potential for the enhancement of individualised maternity care for women and the identification and development of practice knowledge for students, midwives and allied health practitioners.

In the following and concluding chapter the strengths and limitations of the study and a personal reflection undertaking the research process will be presented.

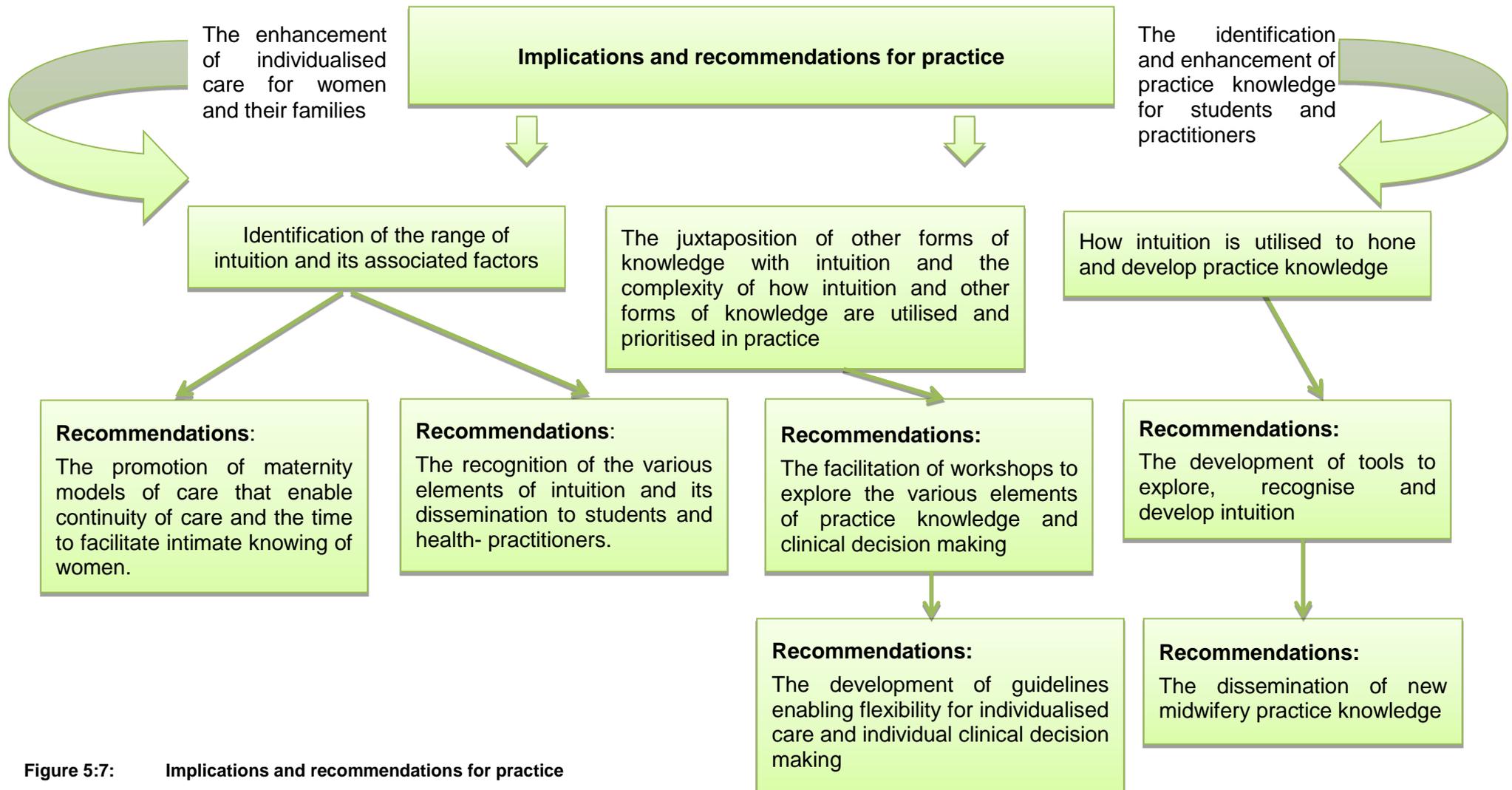


Figure 5:7: Implications and recommendations for practice

Chapter 6 Concluding chapter

In this final concluding chapter the strengths and limitations of the study will now be analysed. Within this chapter it is pertinent to explore personally any questions that it has raised and present the associated recommendations for future research.

6.1 Strengths and Limitations

The strengths and limitations will consider the effectiveness of the chosen methodology and the rigour of the research methods.

6.1.1 The use of descriptive phenomenology as a methodology for the study

Phenomenology was chosen as a methodology to answer the research questions for this study as the descriptive phenomenological method has the potential to clarify phenomena that are difficult to define or rationalise (Le Vasseur 2003). It has been recognised by the literature that the phenomenon under study has not been clearly identified and therefore fulfils this criterion. One of the main strengths of this study has been the transparent identification and definition of the phenomenon. It is evident that the phenomenological method has assisted in this process. As the phenomenologist van Den Berg (1972, p.4) asserted: "phenomenology is the art of the concrete". The study similarly revealed the complexity of the phenomenon in terms of how it could be utilised and prioritised alongside other forms of practice knowledge and be honed to develop the midwives' practice knowledge. It is asserted that investigating the lifeworlds of the independent midwives through a

phenomenological lens has aided this process. The rigour of the research methods will now be considered.

6.1.2 The rigour of the research methods

In terms of assessing the strength and quality of the study, there are a number of criteria that must be met to ensure rigour within a descriptive phenomenological study (Giorgi 1997; Norlyk and Harder 2010). Giorgi (1997, p. 235) asserts that the study must demonstrate “description within the attitude of the phenomenological reduction” and that the researcher must seek “the most invariant meanings for a context”. Norlyk and Harder (2010) maintain that there is a need for clarifying how phenomenological principles are implemented into a study. They further assert that this should include “an articulation of methodological keywords of the investigated phenomenon and how an open attitude was adopted” (Norlyk and Harder 2010, p. 420). The methodology chapter has demonstrated this process and the reader is directed to this chapter (chapter three, p. 64) to demonstrate rigour in these areas.

One of the limitations of the study is that the cohort selected is from a relatively small select group of independent midwives that practice in a context that supports continuity and the time to build intimate relationships. This model of care is in direct contrast to the majority of midwives who practice in the NHS in fragmented models of care. These models do not necessarily promote continuity of care or provide the requisite time for an intimate relationship to develop. It is, however, recognised that qualitative research explores the ‘emic’ or insider perspective (Holloway and Brown 2012, p. 20) and its aim is not to report findings that can be generalised across or recommended for other cohorts of midwives, health practitioners or students (Wolcott 2001). It is also acknowledged that there are a number of models both

within the NHS and privately that utilise the caseloading model, not forgetting student caseloading schemes and the findings may resonate more closely with these cohorts. The caseloading model of care which affords continuity and intimate relationships has been considered the gold standard of maternity provision (Sandall et al. 2013) and should therefore be the recommended model of choice within and without the NHS.

A further possible limitation of using this cohort group is the level of experience they possessed. All of the independent midwives were very experienced in both sectors and it is uncertain whether experiences of intuition would be found so richly in a cohort of less experienced midwives. This is acknowledged by Benner (1984) who emphasised that intuition was associated with expert status and experience.

An additional issue is that a number senior midwives and researchers have recognised independent midwives as having developed additional autonomy (Winter 2002) and leaders in practice development, as they are not constrained by the biomedical model (Davis-Floyd and Davis 1996; Gaskin 1996; De Vries et al. 2013). The study's findings have certainly reflected this view of independent practice. Utilising this cohort has served to elicit principles of highly developed practice that can be recommended across midwives. Whether or not the small select cohort differs from mainstream midwifery, it remains that the study has developed concepts and insights that students, midwives and practice arenas can find useful. It has also added to the scholarship surrounding intuition.

The study has raised a number of questions surrounding the phenomenon of intuition and its utilisation of which some have been identified within the implications

and recommendations for practice. These will now be considered suggesting recommendations for future practice.

6.2 Recommendations for future research

The study has illuminated a number of areas that could be the focus for future research. These concern how intuition occurs within the NHS and within models of practice that do not provide continuity of care; whether a holistic form of knowing can be identified, and if so how this exists; and finally if reflective workshops can identify and develop students' and health practitioners' intuition. These will now be discussed individually.

6.2.1 How intuition occurs within other models of care

From this study it is evident that intuition is an integral part of the independent midwives' practice knowledge, what is not known however, is the scale of its use within mainstream midwifery, outside the independent sector. It is recommended that a quantitative survey investigating the extent of the use of intuition in NHS midwifery cohorts could capture the degree of its existence. If this further study identifies that intuition occurs outside independent midwifery, what is not clear is whether this differs from the range of intuition identified by this study. It is recommended that a further qualitative phenomenological study is then undertaken to explore how the phenomenon is experienced within the lifeworlds of a NHS midwifery cohort.

From this study an intimate knowing of the woman facilitated and appeared integral to the independent midwives' intuition. This was particularly notable when the midwives' intuitive noticing was perceived through the reception of cues. These cues appeared vital in recognising obstetric emergencies, namely diagnosing obstructed labour and post-partum haemorrhage. What was not clear was whether these cues are still perceivable when the woman is unknown to the midwife. One of the midwives was adamant that her intuition was not present when she was caring for a woman she had not previously met. She was not, however, used to working in models without continuity which may have diminished her intuition. This begs the question what are the enablers and disablers of intuition? It is acknowledged that intuition occurs outside independent midwifery, what is not clear however is whether this differs from the range of intuition identified by this study. This study could be replicated utilising a cohort of midwives from the NHS practicing in shared care or team models, which is generally the norm in maternity services in the UK.

6.2.2 Holistic knowing

One of the other forms of practice knowledge identified was situational knowledge. The midwives identified clinical and personal types of situational knowledge within their typography of practice knowledge. What is not clear is whether there are other forms of situational knowledge and how these are utilised in clinical decision making. Both intuition, intimate knowing of the woman and situational knowledge are neglected discourses in terms of their utilisation as evidence. When utilised together, however, they form a sense of holistic knowing. This integration of different levels of knowledge of which intuition is an important component could be the subject for future phenomenological research.

6.2.3 Reflective workshops

The last recommended area for future research is an evaluation of reflective workshops that explore individuals' use and development of intuition and other forms of practice knowledge. The recommendations for practice and education of this study have concluded that workshops could develop and enhance students' and midwives' intuition. What is not clear is whether or not these workshops actually have the potential to achieve this. An evaluation of reflective workshops would illuminate whether they are an effective tool for identifying and enhancing students' and midwives' intuition. It is suggested that different exploratory tools would be required for the novice and the more experienced midwives. Workshops could further elucidate from participants what issues enable or disable their intuitive practice and whether this is concerned with their own individual capacity or as a result of a situational context

Finally it is necessary to present a personal narrative of undertaking the phenomenological study to enable transparency of my research journey.

6.3 Personal reflection of undertaking the descriptive phenomenological study

This reflection, similar to other elements within the dissertation, will be written in parts in the first person to denote responsibility authority of the author in providing a narrative involving the self (Webb 1992). I will reflect on both the process of

undertaking the study and how my view of the phenomenon researched has changed.

It has been identified in the literature, concerning the phenomenology as a research method that the novice researcher often struggles as they have to comprehend a philosophy as well as a research method (Norlyk and Harder 2013). I have however been extremely fortunate of having on my research supervisory team Professor Todres who is a key protagonist in the scholarship concerning the phenomenological research method (Todres 2007; Galvin and Todres 2013) and Dr. Barker who has personally undertaken a phenomenological doctoral study. Notwithstanding, comprehending the research methodology and methods has been a laborious journey. This has however benefited me with knowledge of the principles of phenomenology as well as the experience of undertaking a doctoral study. One of the pitfalls along this road has been the lack of literature surrounding some elements of the phenomenological research methods. This is concerned with writing a literature review for a phenomenological study. In an effort to ameliorate this difficulty for future novice researchers I have written an article concerning this very topic. Once again I was ably supported by my research team in undertaking this process. Another gap in the phenomenological research literature is the process that occurs between free imaginative variation of the transformed meaning units to the general structure. This was undoubtedly one of the most difficult parts of the research analysis process, however also exciting and stimulating.

One issue that struck me continually along the research process was the similarity between the phenomenon of intuition and the research analysis where the phenomenon is intuited. This was almost too close a mirror at times however when clarity did occur there were certain benefits afforded to this process. These included

a further comprehension of both the research method and the phenomenon under study.

At the commencement of the study, I believed that intuition could not be simply a matter of patterning (Benner 1984), as this appeared too one dimensional for what was seemingly a complex phenomenon. I did, however, subscribe to Polkinhorne's view that intuition was enmeshed with other factors including emotion, culture and experience. I was also curious as to whether intuition was connected to mysticism and/or spirituality and if so how was this element of intuition utilised as an authoritative form of knowledge. My current viewpoint is underpinned by the findings of the study and echoes Polkinhorne's (2004) assertions. My view of the phenomenon has however been somewhat altered since the inception of the study and this has particularly centred on the other types of practice knowledge that are utilised alongside intuition and how these are contextually prioritised. What has fascinated me most about the phenomenon is the concept of whether intuition is dependent on the capacity of the individual or the context of the practice situation. I think the answer to this question is that it is dependent on both. This is to be the subject of future reflective workshops which will focus on enablers and disablers of individuals' intuition and how it is prioritised amongst other forms of practice knowledge. In terms of the mysticism/spirituality dimension I do believe it is a part of what constitutes intuition for *some* people and its utilisation was balanced with other forms of knowledge answering my initial inquiry.

The stage of the research that resonated most with me was the data collection phase. This was both fuelled with anxiety and joy. Anxieties included the responsibility of obtaining a rich depth of data whilst protecting the independent midwives' anonymity and maintaining the phenomenological attitude of suspending

belief. Outweighing this sense of anxiety however was the joy experienced. This involved listening to the midwives' heart-warming, at times, breath-taking stories. I felt honoured by the trust this small cohort of midwives placed in me and humbled by the depth and level of their practice knowledge. I am hopeful that the dissemination of this study can in some way repay their acts of generosity in sharing their experiences. The other element from the interviews that resonated with me was the level of emotion experienced by the midwives as they expressed their experiences. I think this was partly due to the intimate connection they felt for the women they cared for, but also the phenomenological method which enables profound exploration of individuals' lifeworlds. My main concern is that I have reflected the midwives' voices faithfully and once again I believe the phenomenological research method has aided this purpose. Keeping a reflexive diary has evidenced the research process and aided in particular data collection, its completion and data analysis.

The other joy that I have experienced during the process of the research has been the hours of discussion spent with my research team also including Dr. Janet Scammell. Their expertise, enthusiasm and support have been second to none and I am eternally within their debt to have received such support.

I am now left with the passion and desire to disseminate the study. The rigour of the study has been demonstrated in the methodological chapter and in the strengths and limitations of the study. What is equally important however, is the communicative concern. I hope to disseminate the study's findings through conferences and publications, and perhaps most importantly through reflective workshops. It is hoped that the findings can resonate more deeply as individual

midwives and students can explore their own sense of intuition and consider ways of utilising it in their own models of practice.

Having presented the implications and recommendations for practice, the strengths and limitations of the study it is now time to provide the final conclusion to the study.

6.4 Conclusion to the study

The most important legacy this study leaves is the potential for the enhancement of individualised care for women receiving maternity care and the identification and development of midwifery practice knowledge. This has been illustrated by three different strands. These comprise: firstly: the identification of the range of intuition and its associated factors; secondly: the juxtaposition and utilisation of other forms of knowledge with intuition and thirdly: how intuition can be honed and assist with the development of practice knowledge. It is hoped that this study will provide assistance in enabling intuition to be recognised as a first person rational form of authoritative knowledge to be utilised, and at times, prioritised alongside other forms of practice knowledge. The transparency provided by the study has certainly contributed in part to this objective. It is sincerely hoped that recognising intuition as part of a holistic knowing will enhance individualised, safe, maternity care for women and autonomous, transparent decision making for midwives.

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Appendix 1



PARTICIPANT INFORMATION SHEET (version 1, July 2011)

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me or either of my supervisors if there is anything that is not clear or you would like more information about (please see contact details below). Take time to decide whether you wish to take part. Thank you for taking the time to read this information sheet.

What is the purpose of the study?

The aim of this qualitative, phenomenological inquiry is to offer an understanding into the nature of 'intuition' as experienced by independent midwives in fulfilment of my doctoral research at Bournemouth University.

Why have I been chosen?

As an independent midwife it is anticipated that you have had a range and depth of experience of the phenomenon being explored.

Do I have to take part?

This is an entirely voluntary process and you are free to withdraw from the study at any stage.

What do I have to do?

You will be invited to participate in an unstructured interview. It is estimated that the interviews will last approximately an hour and would be conducted in an area of your choice, however to safeguard your (and your clients') confidentiality it is anticipated that this will be a private environment. It is important any discussion of particular women and their families will be undertaken in such a way that identifying details (for example, names, dates, localities) will not be communicated to the interviewer.

The interview will be digitally recorded. You will then be sent a copy of the transcript from the interview and will be given an opportunity to discuss this with the interviewer. It is anticipated that these discussions will take place via the telephone or by email; however I would be very happy to visit you again for a further interview if necessary. This is to ensure that my

research truly represents the essence of your experience; however it is recognised that phenomenology as a research method captures a moment in time van Manen (1990).

van Manen, M., 1990. *Researching Lived Experience Human Science for an Action Sensitive Pedagogy*, London, The State University of New York.

What are the possible disadvantages?

There may be the possibility that when retelling past experiences you may encounter an upsetting episode that causes emotional upset. If such an incident occurred it is suggested you seek support from your Supervisor of Midwives. There is also the unlikely event that you may describe experiences that are deemed examples of unsafe practice. If this unlikely event occurs I would again request that you discuss this incident with your Supervisor of Midwives.

What are the possible benefits of taking part?

The study will give you the chance to express your opinion and views on the phenomenon. It is an opportunity to take part in a study that aims to have a positive impact on enabling midwives to support women by using this form of knowledge and will add to the body of information of what constitutes intuition and how it is utilised as a form of knowledge.

Will my taking part in this study be kept confidential?

The excerpts of the taped interview will be given in the researcher's final dissertation paper. The taped interview will not be shared by anybody other than the researcher and the researcher's supervisors of the study. All excerpts of the taped interview given in the final dissertation paper will remain anonymous and you will not be identified. Overall, however, it is acknowledged that confidentiality may be difficult to completely achieve within the confines of the independent midwifery community itself because of the inclusive nature of its philosophy which promotes sharing and learning

A copy of the study will be stored in the library at Bournemouth University. The researcher will retain the taped interview until completion of the study, a period of 36 months and then it will be destroyed. The tape will be destroyed in accordance with Data Protection and the Records Management Code of Practice (DH, March, 2006).

What will happen to the results of the research study?

It is anticipated that the research will be published in a leading peer-reviewed midwifery/qualitative research journal and be presented at a national/international midwifery/qualitative research conference. The research analysis will be in part transformed into a poetic form of writing (known as empathic inquiry) this will be as a result of combining analysed data from all research participants so anonymity will be maintained.

Who has reviewed the study?

The Bournemouth University research committee

Contact for further information?

If you require any further information or agree to participate in this study please contact Jane Fry:

by telephone: 01202968310; or email jfry@bournemouth.ac.uk School of Health and Social Care or write care of:

Bournemouth University,
Finchdean House,
St. Mary's Hospital,
Milton Road,
Portsmouth,
Hants.
PO3 6AD

or contact Professor Todres (research supervisor) on 01202962169 or email ltodres@bournemouth.ac.uk or

Dr. Scammell (research supervisor) on :01202962751 or email jscammell@bournemouth.ac.uk

You will be given a copy of the information sheet to keep

Thank you for taking part in the Study

Appendix 2



CONSENT FORM

Organisation:

Bournemouth University

Title of Study:

Are there other ways of knowing? Independent Midwives' experiences of utilising intuition during maternity care.

Aim of Study:

The aim of this qualitative, phenomenological inquiry is to offer an understanding into the nature and of 'intuition' as experienced by independent midwives in fulfilment of my doctoral research studies at Bournemouth University.

Researcher' Position:

Part time PhD Student, Bournemouth University

Researcher's Name:

Jane Fry

Contact Details

Bournemouth University,

Finchdean House,

St. Mary's Hospital,

Milton Road,

Portsmouth,

Hants.

PO3 6AD

jfry@bournemouth.ac.uk

01202968310

Consent:

- I.....give consent to have an audio recording of myself while being interviewed by the researcher.
- I understand that any discussion of particular women and their families will be undertaken in such a way that identifying details will not be communicated by the interviewer.
- I understand that excerpts of the digitally recorded interview will be given in the researcher's final dissertation paper. The digitally recorded interview will not be shared by anybody other than the researcher and the researcher's supervisor of the study.
- I understand that all excerpts of the taped interview given in the final dissertation paper will remain anonymous and that I will not be identified by name. Overall, however, confidentiality may be difficult to completely achieve within the confines of the independent midwifery community itself because of the inclusive nature of its philosophy which promotes sharing and learning.
- I am not required to answer any specific questions if I chose not to and have the option to withdraw at any time from the interview or study and the digital recording destroyed.
- The researcher will retain the digitally recorded interview until completion of the study, a period of 36 months and then it will be destroyed. The digital recording will be destroyed in accordance with Data Protection and the Records Management Code of Practice (DH, March, 2006).
- The procedure and intended use of the digitally recorded interview have been explained to me by: Jane Fry in an information sheet.
- I understand that I will not be identified in the study and any information given will be anonymised by changing my name in all documentation, data analysis, writing up and any subsequent publication of work or conference presentation relating to this study.
- I.....agree to take part in the study

Signature of Participant.....Date.....

Signature of Researcher.....Date.....

When completed 1 copy to be given to the participant and 1 copy to be retained by the researcher.

Appendix 3

General Risk Assessment Form

Before completing this form, please read the associated guidance on 'I: Health & Safety/Public/Risk Assessment/[Guidance](#).

Use this form for all risks except from hazardous substances, manual handling & Display Screen Equipment (specific forms are available for these).

If the risk is deemed to be 'trivial' there is no need to formally risk assess.

All completed forms must give details of the person completing the assessment.

Risk assess the activity with its present controls (if any) -then re-assess if action is to be taken and after further controls are put in place.

The completed form should be kept within the School/Service/Department.

1. Describe the Activity being Risk Assessed:

Qualitative research involving interviewing participants (independent midwives) in their own homes.

2. Location(s):

Participants' own homes across the South of England.

3. Persons at potential Risk (e.g. Specific Staff only, General Staff, Students, Public etc.):

Participants

Researcher

4. Potential Hazards i.e. What Could Happen?(NB: List hazards without considering any existing controls):

1. Health and Safety issues for the social researcher when undertaking fieldwork in participant's homes.
2. Effects of the interview on participants.
3. Poor standards of professional healthcare practice identified.

5. Control Measures Already In Place:

1. Health and Safety for the Social Researcher:

- Interviews will only take place during the day.
- I will plan the route in advance, utilise satellite navigation equipment and take a map with me.
- I have valid membership of automobile breakdown service.
- I carry essential emergency equipment including a torch.
- I will telephone the participant on the day of the interview and enquire whether any other members of the household will be at home. Details of my itinerary and appointment times (including addresses and telephone numbers) will be left with one of my research supervisors at the university. Confidentiality will be maintained.
- I will notify my research supervisor(s), next of kin of any changes in fieldwork. I will carry a mobile phone which will be switched on at all times should I need to be contacted.
- At the end of fieldwork I will inform research supervisor(s) that the interviews have been completed.

Interview Precautions:

- I will wear appropriate clothing taking account of any cultural norms.
- In multi-storey buildings I will pay attention to safety when choosing lifts or staircases.
- I will let the participant know that I have a schedule and that others are aware of my location.
- My mobile phone will be left switched on.
- I will assess the layout of the dwelling and the quickest way out. As I will be interviewing in private dwellings it will be safer to stay in the communal rooms, although to some extent I am to be guided as to where the participant would prefer to be.
- I will always carry identification such as my Bournemouth University Staff card.
- I will carry a suitable amount of money to cater for unexpected expenses, such as

having to use a public telephone or to use a taxi.

- I will be aware of cultural norms and will be aware of my body language and that of the participant.
- I will try to establish the appropriate social distance by neither being over-familiar or too detached.
- Because of the voluntary nature of participants opting into the research and their professional capacity it is hoped that any risk of physical or mental abuse to the researcher will be extremely low/non existent. Participants will have been provided with written information outlining the purpose of study and have been invited to participate. Thus the voluntary nature of being involved will greatly lessen any risks to myself. However if participants or members of their households become abusive, I will end the discussion and leave the situation immediately.
- If an incidence has occurred it will be recorded on the Bournemouth University's Accident/Incident form. I will discuss any serious incidents with my research supervisors and if it has impacted on my well-being I will report it to the health and safety office for the School of Health and Social Care and if necessary to the local police force. I may need to be referred to counselling if a serious incident has occurred during the course of fieldwork or even take a leave of absence (sickness leave).
- Appropriate debriefing: this may help the researcher come to terms with an incident and enable completion of research. If debriefing sessions are required it is essential that confidentiality of the respondent is maintained.

Completion of fieldwork:

- I will endeavour to discuss with my research supervisors any difficulties in adhering to the guidelines as per my risk assessment.

2.Effects of the interview on participants:

- If the participants become distressed as a result of discussing their experiences I am faced with some options:
 - Should the interview be stopped and vital information lost or should the interview continue? It is important to consider that for some participants having an opportunity to discuss an emotional event may in itself be therapeutic, therefore once the participant has recovered I will ask her whether she wishes to continue, change the subject, or terminate the interview. However, the participant may feel obliged to continue with the interview, therefore I will assess the situation and if I feel it is in the best interests to terminate the interview I will do so. I will also make it clear that my role is one of researcher, not practicing midwife, educator or supervisor of midwives.
 - It has been suggested that researchers are ethically bound to deal with any sensitive issues raised by the participant, by acknowledging her emotions and listening sensitively. It would not however be appropriate to probe for further information even if valuable information may be lost to the research.
 - If the midwife would like to discuss any disclosed experiences further I will

suggest she accesses the debriefing sessions provided by her Supervisor of Midwives.

3.Poor professional standards of healthcare practice identified:

- I will be clearly discussing with the midwife the purpose of my research, and will inform them that confidentiality will be maintained unless poor practice is identified whereby I am duty bound to discuss with the appropriate authorities. In the unlikely event that a midwife's story reveals an amount of unacceptable practice I will discuss this initially with the midwife and requests she seeks support wither personal Supervisor of Midwives. I will also personally discuss this with Dr. Leamon who is both a research supervisor and Supervisor of Midwives at Bournemouth University. Together the midwife's story will be reviewed and where further investigation regarding the midwife's practice is felt necessary, contact to the relevant supervisor of midwives will be made, to uphold women's' and their families' safety. If the midwife is reluctant to disclose poor practice to her Supervisor I will inform her I am duty bound to discuss the issues and will contact the research Supervisor of Midwives, Dr. Leamon, in the first instance.

6.Standards to be Achieved: (ACOPs, Qualifications, Regulations, Industry Guides, Suppliers instructions etc)

Nursing and Midwifery Council, 2008. Code of Professional Practice for Nurses and Midwives.

NMC: London

Bournemouth University, 2010. Lone working Guidelines p.2-3

Bournemouth University, 2009. Research Ethics Code of Practice: September.

Nursing and Midwifery Council, 2004. Midwives Rules and Standards. NMC: London

7. Are the risks adequately controlled (bearing in mind 4. & 5.)? **Write 'Yes'**

If **Yes**, Step 8: Ensure that those affected are informed of the Risks and Controls:

Confirm how you have done this (e.g. written instructions):

Midwives will receive a information sheet, outlining purpose of study, confidentiality and what they are expected to do.

Prior to commencing data collection each participant will be required to sign a consent form.

Detailed fieldwork itinerary to be provided for research supervisors/next of kin.

Then, complete boxes below and the assessment is finished until the review date(s):

| | | | | | |
|----------------------------------|--|--------------|------------|---------------------|--|
| 9. Person(s) Who did Assessment: | Jane Fry | 10. Date: | 18.07.2011 | 11. Review Date: | |
| 12. Checked By: | Dr. Scammel Professor Todres | 13. Date: | | 14. Review Date: | |

If **No** (to Q7) go to next section and estimate 'Residual Risk'.

Estimating the Residual Risk:

15. Choose a category that best describes the degree of harm which could result from the hazard,

then choose a category indicating what the likelihood is that a person(s) could be harmed.

Check only **ONE** box within the table which matches both of your choices.

| | | | |
|------------------------------|---|---|---|
| Degree of harm likelihood | Slightly Harmful (e.g. minor injuries such as minor cuts/bruises not always requiring first aid) | Harmful (e.g. serious but short-term injuries such as broken bones or curable disease) | Extremely Harmful (e.g. would cause fatality, major long- term injuries or incurable disease) |
| Highly Unlikely | Trivial Risk <input type="checkbox"/> | Tolerable Risk <input type="checkbox"/> | Moderate Risk <input type="checkbox"/> |
| Unlikely | Tolerable Risk X <input type="checkbox"/> | Moderate Risk <input type="checkbox"/> | Substantial Risk <input type="checkbox"/> |
| Likely | Moderate Risk <input type="checkbox"/> | Substantial Risk <input type="checkbox"/> | Intolerable Risk <input type="checkbox"/> |

| | | |
|--|-------------|---|
| 16. Then note the advice below on suggested action and timescale | | |
| Residual Level | Risk | Action and Timescale |
| Trivial <input type="checkbox"/> | Risk | No action is required and no documentary records need to be kept. |
| Tolerable Risk <input type="checkbox"/> | X | No additional controls are required. Consideration may be given to a more cost-effective solution or improvement that imposes no additional cost burden. Monitoring is required to ensure that the controls are maintained |
| Moderate <input type="checkbox"/> | Risk | Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and limited. Risks reduction measures should be implemented within a defined period. Where the moderate risk is associated with extremely harmful consequences, further assessment may be necessary to establish more precisely the |

| | |
|--|--|
| | likelihood of harm as a basis for determining the need for improved control measures. |
| Substantial Risk <input type="checkbox"/> | Work should not be started until the risk has been reduced. Considerable resources may have to be allocated to reduce the risk. Where the risk involves work in progress, urgent action should be taken. |
| Intolerable Risk <input type="checkbox"/> | Work should not be started or continued until the risk has been reduced. If it is not possible to reduce the risk even with unlimited resources, work has to remain prohibited. |

| | | |
|---|-------------------------|-------------------------|
| <p>17. If 'Moderate' 'Substantial' or 'Intolerable':</p> <p>What New Control Measures are to be Considered to reduce risk?</p> | <p>18. Referred to:</p> | <p>19. On Date:</p> |
| <p><u>20. Ensure those affected are informed of the Risks & Controls</u></p> <p>Confirm how you have done this e.g. written instructions: Information leaflet provided to participants contains information concerning the research and who to contact in case of any</p> | | |

issues that arise during the course of the interviews.

| | | | | | |
|---|-----------------------------------|--------------|----------|---------------------|--|
| 21. Person(s) Who did Assessment: | Jane Fry | 22. Date: | 18.07.11 | 23. Review Date: | |
| 24. Checked By: | Professor Todres Dr.Scammel | 25. Date: | | 26. Review Date: | |

Please complete the form in conjunction with the guidelines Risk Assessment:
Guidelines for Lone Interviewing.

The student should nominate a contact person who:

- **will be aware of the student's planned itinerary during interviewing activities**
- **has agreed to be responsible for alerting appropriate bodies should the student fail to return at the expected time.**

It is essential that the nominated contact person is provided with full details of the student's planned itinerary and that a copy of the completed form is also submitted to the Master's Framework Research Administrator (MFRA) and the student's supervisor(s) prior to any interviews taking place.

Student: Jane Fry Mobile 07590256346.....

Supervisors: Professor Les Todres...Contact: 01202962169 or email:
ltodres@bournemouth.ac.uk

Dr. Janet Scammell... Contact 0120162751...or email:
jscammell@bournemouth.ac.uk

MFRA Contact Eva Papadopoulou 0120262119 ...or email
epapadopoulou@bournemouth.ac.uk

NOMINATED CONTACT PERSON

(student to notify nominated contact on completion of each interview)

NameGary Wensley.....Tel
07791837793.....

Address ...8 Wilton Place, Southsea, Portsmouth, Hants. PO5 2BG
.....

The nominated contact should inform the following in the event of adverse
incident/failure to return from interview:

| Name/authority | Contact details |
|--|-----------------------------|
| Sue Way..... (Lead Midwife for Education) 01202961861..... | sway@bournemouth.ac.uk..... |

Appendix 4



School of Health and Social Care

Research Governance Review Group

Feedback to student and supervisors

Student: Jane Fry

Title; Are there other ways of knowing? Independent Midwives' experiences of utilising intuition during maternity care.

Re-review report prepared by: Martin Hind.

Date: 19.12.11

Dear Jane

Thank you for re-submitting your study to the research governance review group (RG2) in light of your initial report dated 14.12.11. Your amendments have adequately addressed the initial points raised and your study is now approved to proceed immediately. This approval will be technically ratified at the School Postgraduate Committee on 20th February 2012, but you do not need to await this event to proceed.

Thank you for taking the time to submit your study to the research governance review group. Please do not hesitate to contact Martin Hind (RG2 co-ordinator) if you have any queries, or need further clarification in relation to this feedback on your study proposal.

Yours sincerely

A handwritten signature in black ink, appearing to be 'MH', written in a cursive style.

Appendix 5

Midwife 3 Debby-Meaning Units and Transformation Stages

| Meaning Units | Transformation 1 | Transformation 2 |
|--|---|--|
| <p>1. I can, I can think of one example and in fact I think my intuition was maybe not right, is that ok?</p> | <p>1. M3 wishes to describe a situation when her intuition was not right.</p> | <p>M3's intuition is not always confirmed as correct</p> |
| <p>2. Ok, in that situation I was caring for a primip who had a breech baby on board and was planning a home birth and I remember I woke up one morning and I just felt I've got to go: she lived she was in (place name), quite some distance from me.</p> | <p>2. M3 describes an experience where she had been caring for a woman with a baby presenting by the breech position planning a home birth. She remembers waking at night with a strong feeling that she had to go and visit this woman who lived some considerable distance away.</p> | |
| <p>3. And I just thought I've got to go, this was very early in the morning and I just got up and drove to her house and sat outside</p> | <p>1. She felt strongly she had to go and drove to her house at an early time in the morning and waited outside until she</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
|---|--|---|
| <p>until it felt like a reasonable time that I could knock on the door and (laughs).</p> <p>4. And the baby was fine and, and in fact she, she didn't labour she, she ended up having a caesarean, a bit, probably a few days later and her membranes had already ruptured.</p> <p>5. And I think I was certainly less experienced than I am now, and I had much less experience of breech birth so I just felt uneasy and so I don't know if that's the sort of thing you mean?</p> <p>6. I felt really uneasy and I don't know if I felt uneasy, I felt I had to go and so I got up and went (laughs).</p> | <p>considered it was an acceptable time for her to call on the woman.</p> <p>4. She discovered the baby was fine and consequently the woman did not go into labour she had a caesarean section a few days later when the woman's membranes had ruptured.</p> <p>5. At the time of this event M3 considered that she was much less experienced caring for women with breech births and consequently felt uneasy.</p> <p>6. M3 describes how this feeling made her so ill at ease she was moved to act.</p> | <p>5. M3 considers that her felt sense to act imperatively may have been due to a feeling of anxiety and a lack of experience.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
|--|---|---|
| <p>7. Yeah and everything was fine so that's an example of intuition not being what's the word I'm looking for you know, not playing out maybe , but I felt I needed to go.</p> | <p>7. M3 relates how despite this strong desire to visit the woman in the event all was well, she feels this is an example of where her intuition was not confirmed by subsequent events.</p> | <p>7.On some occasions M3's intuition is not confirmed as correct</p> |
| <p>8. I suppose another example which because intuition is, who knows what it is? I've heard I a midwife say that intuition is about our experience and our observations, it's not really this sort of airy fairy spiritual thing that, that perhaps some other people think it is.</p> <p>9. The other example that I felt I wanted to do a CTG on a client which would absolutely not be my normal practice to want to do a CTG but it was given</p> | <p>8. M3 considers that intuition is difficult to clarify and relates another midwife's view that it is experience observations rather than an ethereal spiritual concept.</p> <p>9. Another experience M3 describes is when she wanted to undertake a cardiotocograph monitoring of a woman's fetus's heartbeat although</p> | <p>9.An example of the phenomenon is described as a trigger to undertake an action which was atypical of her practice, this was coupled with her</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>the whole clinical picture.</p> <p>10. And I had heard when somebody else was auscultating the fetal heart I heard, I wasn't completely comfortable with what I heard and so you could say that was intuition.</p> <p>11. In fact I described it to a midwife as intuition, and it was what's the word I'm looking for, an accumulation of instinct, of clinical picture of the progress of the labour of what I'd thought I might of heard it was, it was the whole thing, but my gut instinct was that I needed</p> | <p>this would not be her normal practice however looking at the whole situation she was moved to act.</p> <p>10. M3 describes the experience as feeling uneasy about a fetal heart during an event when another midwife had been monitoring the heartbeat which she believed may be intuition.</p> <p>11. M3 had previously described this experience as intuition to another midwife; she now considers it was an amalgamation of intuition, a clinical situational viewing of the woman's labour and what she felt she had heard, her intuition however was that</p> | <p>knowledge of the situation.</p> <p>10. An example of the phenomenon being explained as an utilisation of the sense of hearing a baby's heart beat.</p> <p>11. The phenomenon is described as a multiplicity of constituents: an assessment of the overall picture of labour, a listening to the fetus' heartbeat and an intuitive feeling which informed her to seek out further knowledge of the woman's situation.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
|---|---|------------------|
| <p>to have a clearer picture of what was going on with that woman.</p> <p>12. Before this, this was a primip who had an extremely long latent phase of labour she'd had minimal sleep for several days and certainly no sleep for a couple of days she'd been vomiting for more than 24 or about 24 hours at that point.</p> | <p>she needed to have a clearer knowledge of the whole practice situation.</p> <p>12.M3 describes the background context to this event which concerned a woman who had experienced a long early stage of her labour with very little sleep and had been vomiting for about 24 hours.</p> | |
| <p>13. And we transferred to hospital as was our plan but earlier in the labour because she hadn't actually got into labour but she'd run out of coping.</p> <p>14. And the midwife who greeted us: it was also an IVF pregnancy, I didn't tell you that earlier which,</p> | <p>13.M3 describes how the woman was transferred into hospital earlier than planned as she was no longer able to manage at home.</p> <p>14. M3 and the woman were greeted by the midwife. M3 relates how this was an IVF</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
|---|---|------------------|
| <p>which in a lot of ways shouldn't make any difference but maybe it does make a difference to people's care and, and certainly I don't know that it would make a difference to my care but the system, the system does tend to treat IVF pregnancies as more precious which I think every pregnancy's precious but I'm sure everybody thinks that.</p> | <p>pregnancy which she does not consider should make a difference however she asserts that the hospital staff tend to treat these pregnancies as more valued, M3 believes all pregnancies are equally valuable.</p> | |
| <p>15. I somehow felt it was remiss not to do not to do a CTG at that stage or I did want her to do one given the whole clinical picture and given the fact that I was unsure of what I'd heard when she listened in with the sonic aid.</p> | <p>15. M3 felt it was inattentive of the hospital midwife not to electronically monitor the baby at this point , she believes one should have been done due to the who clinical picture and the lack of clarity of the fetal heart sounds.</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>16. So is that instinct? Is it clinical? It's probably a bit of a combination but I think maybe in that situation it was actually more the clinical skills of the whole picture.</p> <p>17. Afterwards the woman was admitted, to the antenatal ward and she was kept there all day and nobody listened to her fetal heart at all, but I did because I, and when I listened it was always fine.</p> | <p>16.M3 questions whether this situation was due to intuition or experience and believes it was more than likely clinical experience in terms of the overall assessment of the woman and fetus.</p> <p>17. After this event the woman was moved to an antenatal ward where there was a lack of monitoring of the woman by the hospital staff, however M3 continued to monitor her and when she did it was always within normal limits.</p> | <p>16.The phenomenon is questioned in terms of whether the experience of intuition was in part or fully down to situational practice knowledge.</p> |
| <p>18. But I kept listening because I needed to be reassured and I know as a midwife that at two centimetres a woman is very often on her own at home and nobody's listening in. And it could</p> | <p>18. M3 kept monitoring the fetal heart despite recognising that a woman often laboured at home without monitoring at this early stage of labour. M3 however continued to monitor driven by her</p> | <p>18. Despite no practice rationale to act in this situation intuition was the driving force to take steps juxtaposed with a situational knowledge.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>have been perfectly reasonable to send a woman home at that stage and nobody would be listening but given the whole picture my instinct, my intuition was that I needed to hear.</p> | <p>intuition and the whole assessment of the situation.</p> | |
| <p>19. And so I listened throughout the day and again, later in the day I heard something that I was unsure about and I asked the midwife if I could perform a CTG which she reluctantly agreed to and unfortunately that didn't happen because there was no equipment available.</p> | <p>19. This lack of monitoring continued throughout the day and when M3 heard something she was not certain of and requested electronic monitoring, there was no equipment to undertake this.</p> | <p>19. The midwife is prevented from utilising her intuition due to lack of resources and being ignored in the hospital.</p> |
| <p>20. And I asked her, the family asked if she would do it later and in fact she</p> | <p>20. The family also asked whether the hospital midwife would</p> | <p>20.It appears that the midwife had been correct to act on the</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>didn't she didn't do it at all over night. And then when, when the baby was monitored the next morning the trace wasn't good but I mean it was a long, it may well have been fine the night before but we don't know and there was a very long time lapse and when it was put on it wasn't good.</p> <p>21. It was definitely my experience of listening to fetal hearts that's really important and you know I work in the community so I haven't got help immediately to hand, so I feel that it's really important to me to know as well as I can from listening to a fetal heart that it's normal.</p> | <p>electronically monitor her baby however this did not occur during the night.</p> <p>When the baby was eventually monitored the following morning the result was not good, M3 however does relent that it could have been within normal limits the previous evening as there has been an extensive time that had passed.</p> <p>21. M3 believes in this situation the essential skill was the ability to detect whether the baby's heartbeat is normal or not , this has been an essential skill to develop in a community setting where there is no immediate assistance .</p> | <p>phenomenon. It cannot however be absolutely certain.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>22. I'm going to just jump to again to something else: I was challenged about my auscultation of the fetal heart in labour recently and I was actually criticised for my auscultation of the fetal heart.</p> | <p>22. M3 relates how she was recently called into question about her monitoring of a baby's heartbeat during labour.</p> | |
| <p>23. But I feel 100% confident in my not in my ability because I'm not the sort of person that you know, I reflect and I agonise and I always think I could do better so I'm not I wouldn't say I feel 100% in my ability but I feel you know 99 point something % sure that I transferred a mother and baby in good condition.</p> | <p>23. Despite this challenge M3 describes how she is very confident about her monitoring, against a background of reflection in an effort to improve herself. She believes however in this situation she had transferred a mother and baby into hospital in a very good condition.</p> | |
| <p>24. I had heard nothing to make me concerned and as, what I'm saying is you</p> | <p>24.M3 on this occasion had not been alerted to anything worrying and is</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
|---|--|------------------|
| <p>know, I work away from help and I want to be as sure as I can be that all is well and that you know that if I need help I need to be planning ahead for transfer.</p> <p>25. And so I guess I would think that my ear is fairly keen to be listening to babies. I feel a bit conceited in saying this but that's my you know that is my experience and in the case where I was criticised I feel very confident in my skills.</p> <p>26. And so this time you know completely a converse I'm in a hospital, I couldn't be in a safer space, but I wasn't sure, I didn't feel confident in what I was hearing and I</p> | <p>always as sure as she can be when in the community that all is ok and that if assistance was required she would have a future strategy for any event.</p> <p>25. M3 relates how she has a honed skill in monitoring babies, and whilst she feels arrogant relating this in the case she was challenged she felt very self-assured in her monitoring.</p> <p>26. M3 compares this ironically with her intuitive experience where she was seemingly in the safest place and yet she was not sure what she was hearing and wanted to follow it up.</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
|---|---|------------------|
| wanted to pursue that. | | |
| <p>27. So I feel that makes me a balanced practitioner because in this situation I did lots of things that you know, I wanted the woman to have pethidine, I wanted her to have fluids I wanted her to be monitored, I wanted her to have an epidural (laughs) all things that I would normally be fighting to save a woman from. But that is experience isn't it, it is experience of watching women in labour.</p> | <p>27. M3 describes on reflection that although not her usual practice she wanted this woman to have a number of interventions including pain relief, intravenous fluids and electronic monitoring normally interventions would she try to protect a woman from having, she feels this makes her a well-adjusted practitioner and has learnt this through experience of caring for women in labour..</p> | |
| <p>28. So yeah, it is very hard to and, and pethidine too, we talked about the woman having pethidine, I mean I, I think pethidine is a horrible drug and yet my intuition or experience and</p> | <p>28.M3 describes how she felt driven to recommend use of a pain relieving drug that she usually considers to be abhorrent whilst she does not have extensive experience of</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>actually I've got very little experience of pethidine because it's not a drug, I've used very much. But my intuition, my experience, whatever it is said that pethidine would help this woman.</p> <p>29. And my experience is also not my own experience (coughs) it's drawn from listening to other midwives and reading and, so it's not just my own clinical experience.</p> <p>30. I feel quite traumatised by (the event)I wasn't traumatised, I feel sad, I feel huge amounts of sadness that I wasn't able to make the experience better for that woman and</p> | <p>utilising this drug, in this experience her intuition or experience was informing her this would be useful.</p> <p>29. M3 believes this information is drawn from a combination of experience, theory and interprofessional dialogue.</p> <p>30. M3 considers her emotions following the experience and feels upset that she could have improved the woman's birth experience or protected her from the hospital.</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>that I wasn't able to protect her from the system, that I wasn't able to get better for her from the system</p> | | |
| <p>31. And I know that I improved her experience and the family have told me and they are grateful to me and they think I helped them have a good experience or a better experience and I'm sure I did, but I wish I could have made it even better but maybe I couldn't maybe you know, this was just going to be a hard labour, no matter what.</p> <p>32. But I think I always do think I could do better and I think that perhaps I should have been more assertive on her behalf</p> | <p>31. M3 however realises that the woman was thankful to M3 and felt she had improved her experience and although she still would have liked to improve the situation ponders whether the woman was going to have a difficult labour whatever had happened.</p> <p>32.M3 considers how she always could do better in a situation and wishes she had been more assertive</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>but that's a really difficult one because I've still got to go back in and work with people and it's not my nature to be hugely assertive.</p> <p>33. And I was quite, actually that's very interesting as well, because actually I think I'm more assertive than I feel because that's often happened to me, people have said to me that I come across as quite assertive, when I don't think I am at all so, I probably actually did OK but I feel I could have done better for her.</p> <p>34. So having this gut instinct and a very, sort of strong instinct which firstly was saying this woman</p> | <p>in the situation however balances this with this is not a normal way of acting for her and also that she has to continue to work with people in the hospital.</p> <p>33. M3 considers how she can come across as assertive to others more than she realises so she may have been assertive enough. She still however believes she could have improved the situation for the woman.</p> <p>34. M3 recounts how this strong sense of intuition which was telling her that</p> | <p>34. M3's intuition informed her specifically to enact interventions to meet the</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>needs pethidine, this woman needs fluids, this woman needs a CTG.</p> | <p>the woman needed pain relief, rehydration and electronic fetal monitoring.</p> | <p>woman's needs</p> |
| <p>35. I think I feel that my instinct was correct, so it probably is actually empowering because you know the woman did need fluids, she severely needed fluids I feel sad that she didn't get more fluids and she didn't sort of get them sooner and more that it wasn't done more proactively because it possibly could have changed the course, possibly could have changed the course of her labour.</p> | <p>35. M3 feels her intuition was right in this experience and finds this self-assuring as she feels the women did need these interventions. M3 remains upset however that her intuition was not acted upon as if it had the woman's labour could have been improved.</p> | <p>35. M3 felt empowered when her intuition was confirmed as correct by the events that occurred.</p> |
| <p>36. So I suppose I feel a slight regret that I didn't fight harder, as I'm saying that I wasn't more assertive, but I also feel</p> | <p>36. M3 laments that she was not more assertive however remains more self-confident and will from this learn to trust her</p> | <p>36.Confirmation of events enabled M3 to feel empowered and have more trust in her intuition.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>empowered and I will learn you know I will, I'm sure I will carry that forward into other experiences to trust my instincts. Because I was correct I believe, year. M2 was then asked if she wanted to say any more about the first experience described:</p> | <p>intuition more and utilise it on other occasions as she believes it was right in this situation.</p> | <p>This supported her to utilise her intuition in her future practice.</p> |
| <p>37. Gosh that's harder, because that was quite a few years ago I think it was to do with my level of experience but I think that it was a perfectly reasonable thing to do.</p> | <p>37. M3 believes that during that occurrence she had a lack of experience however she believes that she acted rationally in the situation.</p> | |
| <p>38. A woman who with ruptured membranes, well I think they were ruptured at that point, I can't remember, she did have a prolonged rupture of</p> | <p>38.M3 describes how she thinks the woman had ruptured membranes with a baby presenting during the breech which is a complex situation</p> | <p>38. Disconfirmation of M3's intuition enabled her to realise it was a lack of practice experience which has assisting her in honing her practice.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>membranes before her caesarean I think you know, it was a high risk situation, a woman with a breech baby I guess I think all our, all my experiences add up to me having more confidence often, often it's not to act it's often to wait longer before acting.</p> | <p>however considers that her growth in practice knowledge has enabled her to wait longer in a situation rather than act immediately.</p> | |
| <p>39. And it's probably given me experience to just to be confident that all is normal unless proven otherwise.</p> <p>40. I can't think of specific examples but, you know listening to a fetal heart in labour you know and there'll be decelerations, as a newly qualified midwife I would have been terrified of any decelerations and you</p> | <p>39. Practice experience has enabled M3 to be self-assured that all is low risk unless verified to the contrary.</p> <p>40. M3 gives the example of how when first a midwife she would hear the fetal heart slowing down and would be afraid, however now she knows that this fetal heart rate can be low risk.</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>know now I know</p> <p>decelerations can be completely normal and (coughs) excuse me.</p> <p>41. So I think that that is really, probably one of the biggest changes in in how I feel that I feel quite happy to wait to listen to a heart rate and the check.</p> <p>42. The case I was challenged on for example there was one deceleration down to 106 I'd recorded in my notes and I was criticised for not transferring, for that reason</p> <p>43. But that to me is absolutely the woman was coming up to the second</p> | <p>41. M3 relates that through experience it has given her the confidence to wait before listening to a fetal heart or performing an examination.</p> <p>42. M4 describes how she was called into question over a documented fetal heart deceleration to 106 beats per minute and how she was challenged for not transferring the woman to hospital at this point.</p> <p>43. M3 describes how she considers this situation normal in the context that</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>stage, she wasn't in the second stage but a baby that's being squeezed you know so that, I don't know if it's intuition or experience there but I think it's more again more experience but you know but, I do think that is experience you know you're used to listening to fetal hearts.</p> <p>44. You're used to watching a woman in labour I felt very confident that that baby was ok at that point.</p> | <p>the woman was entering the second stage and the baby was therefore becoming compressed by the birth canal; she is not sure whether this is having the experiential knowledge of fetal heart auscultation or intuition.</p> <p>44. M3 feels very self assured that through her experience of observing labouring women she knew the baby was alright.</p> | |
| <p>45. But another thing that's just come into my head I mean another sort of intuitive feeling is certainly when I first meet a woman ,I have a very strong gut instinct whether</p> | <p>45. M3 recounts how another experience when she has intuition is when she firsts meets a woman she intuits whether she will have a good working relationship with them.</p> | <p>M3's intuition specifically informs her whether or not to work with a woman.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>they're a good person , no that's not the right word, whether I should be working with them whether I'm going to have a good relationship with them.</p> <p>46. And maybe even you know, I have a strong instinct that this woman will give normally and everything will be fine.</p> <p>47. And I have had instincts of women that will be more challenging and I have taken them on as clients and my instinct is right.</p> <p>48. My first instinct, my gut instinct usually on a first meeting is right, but that was an aside what I</p> | <p>46. She describes how sometimes she intuits the way the woman will birth and that it will all be all right.</p> <p>47. She has also had intuition where she realises certain women will be testing and this sense of intuition has been correct.</p> <p>48. Her intuition in terms of how they will get on is right however what M3 considers more important is her intuition which</p> | <p>46. M3's intuition specifically informs her that a woman will birth normally.</p> <p>47. When M3's intuition specifically informs her that woman will be challenging, this has been confirmed as correct on subsequent events.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>was going to say you know I often have an instinct whether a woman will give birth easily, or you know normally or not.</p> <p>49.I'm not always right on that one and I definitely, I had one client in particular who I found very challenging and I didn't really believe she would give birth, and she had beautiful, quite quick beautiful birth so um you know my instinct is not 100% right on that one.</p> <p>50. But I'm sure lots, lots of midwives walk into a room and say you know this woman's going to have a caesarean we just have an instinct.</p> | <p>informs her whether the woman will birth without problems or not.</p> <p>49.M3 describes however that she is not always right on this account and exemplifies how she worked with one woman who she found very difficult birthed quickly and easily.</p> <p>50. M3 relates how she and many midwives can enter a room and know that a labouring woman will have an operative birth as many midwives have a sense of intuition.</p> | <p>49. When M3's intuition informs her specifically about how a woman will birth, this is not always confirmed as correct.</p> |
| <p>51. I don't know what it is</p> | <p>51. M3 describes however</p> | <p>51. M3 utilises her</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>but it's not always in labour for me because I'm meeting women antenatally so it's not how they're coping in labour it's them as a person, but again, there's more than instinct, I'm sure that we're reading a lot of who they are as a person, how they cope with life. I don't know quite you're reading the whole picture again.</p> <p>52. I suppose you're looking at maybe, you could be looking at a woman's past life experience, has she been adopted? Has she been sexually abused? Does she have difficult relationships with her parents, her husband or partner? Maybe how she is as a mother, how she</p> | <p>for her she not only possesses that sense of intuition when women are in labour but also in the antenatal period . She believes this however is not just intuition but also observing individual characteristics and coping mechanisms and an overall assessment of the woman.</p> <p>52. M3 details this assessment as an observation of the woman's past life history in terms of adoption, sexual abuse, relationship difficulties with parents and husbands or partners. She also observes her mothering , her ability to cope with pregnancy and life, whether she is a</p> | <p>intuition alongside situational knowledge of the woman to inform her specifically how a woman will labour and birth.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>deals with the aches and pains of pregnancy how she copes with life (laughs) you know there's a lot of that that you're observing is she positive, is she prone to depression is she happy, sad you know there's lots and lots of things that make up the picture of who she is and I think that has a huge impact on how she might cope might cope in labour and give birth.</p> | <p>positive or happy person or prone to depression. M3 considers there is a complex image of how a woman is and she believes this directly impacts of how they will manage in labour and how they will birth.</p> | |
| <p>53. I had one client who was very challenging and my instinct was actually that all would be well and this is going to be a bit difficult for confidentiality maybe, but all was not well with her baby so my instinct, possibly was not right my instinct with her as a person was correct.</p> | <p>53. M3 describe how she worked with one woman who she found very difficult and her intuition informed her that all was not going to be well and as it turned out her baby had problems which validated to M3 that her intuition of this woman was right.</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>54. My initial instinct was that she was going to be very challenging, very hard work, but I did believe that her baby would be fine.</p> <p>(Experience details could not be given to protect woman's and midwife's confidentiality).</p> | <p>54. Her initial intuition was that the woman was going to be difficult and arduous to support however she did believe all would be well.</p> | |
| <p>55. Well one thing that I did do I engaged heavily with supervisors and I documented you know loads and loads of confidential documentation, because I was aware of the potential for things not too well in that case and I was proven correct.</p> | <p>55.As a result of her intuition one of her actions was to seek support from her supervisors of midwifery and meticulously record all information, as she began to intuit that all would not go well and again her intuition proved correct.</p> | |
| <p>56. And yeah I think things were already really</p> | <p>56. And M3 realised that the woman was becoming</p> | <p>56. M3 utilises her intuition to increase her vigilance with her record</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>going off track but I very carefully documented everything and it was really useful and I think it you know, it was very useful for my mother, I particularly needed to defend myself, but to prove that I had given adequate care my records really supported me in that case thank goodness.</p> | <p>high risk however very meticulously recorded all aspects of care and this proved helpful for herself and the mother. In this case she was called into question again however there were no repercussions as she had given good enough care which was underpinned by her documentation.</p> | <p>keeping which helped her support both herself and the woman.</p> |
| <p>57. I think it hasn't changed my it perhaps ought to change my practice in that I ought to listen to my instinct maybe and walk away from some clients but for whatever I feel unable to do that, you know, some of that's to do with needing an income and I also believe you know I have this, this misplaced sense that you</p> | <p>57. M3 considers how this has affected her life as a midwife and believes on the one hand she feels she should not work with women when she intuits that they will be difficult. She does however relate how this is teamed with a need to earn and also a belief that if someone has chosen her as midwife despite her sense they</p> | <p>57.The complexities of working independently can affect whether M3 utilises her intuition or not.</p> |

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| <p>know that if somebody needs a midwife and they want me to be their midwife you know I want to do that. I don't mind things being challenging. But there's only so much of that you can do.</p> | <p>may be difficult she believes this is enough reason to work with them. In some ways she does not worry about this challenge however could not continually undertake this.</p> | |
| <p>58. But I quite liked challenging women, I do quite like that, so, I don't know that I ,perhaps I ought to listen to my instinct</p> <p>59. I would do the same again with the record keeping because you know; it was the right thing to do as far as the outcome. I don't think that I could have done anything different maybe I could yeah, but you know I acted I mean the woman was making a lot</p> | <p>58. M3 reflects how although she does enjoy working with difficult women she should however also pay attention to her intuition.</p> <p>59. M3 reflects how she would not have changed anything as far as documentation she considers how she could have been more assertive with the woman in terms of the care she was requesting however on reflection does not believe she could have been.</p> | |

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| <p>of the choices, maybe I could have been more forceful in the way I said it, but I'm not sure I could have been, actually, so I'm not sure that it's changed anything.</p> <p>60. Sometimes it's stronger than others sometimes, you know either, I suppose it's brought positive or negative. I suppose there's lots of that are in the middle that are, there's less strong feeling either way about. But some women I really identify with and feel, I really, really want to work with you</p> <p>and some women I know are going to be challenging and there's a lot in the middle that year, but I think that is, I think</p> | <p>60. M3 describes how her sense of intuition is more pronounced and believes it has given both negative and positive feelings; she also describes how sometimes her intuition is less where it reaches the midpoint of a continuum between negative and positive. M3 relates how her intuition when she first meets women either who she decidedly wants to work with or that she will find difficult and some who fall into the midpoint of this.</p> | |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>that I do have quite a sense when I first meet somebody.</p> <p>61. I can remember it very vividly. I cared for her twice actually she's another very interesting case the first time I met her, I had a horrible journey to her, in the pouring rain in the dark and it was miles away and I was thinking oh I really don't care if I don't get this client and when I got there I really liked her (laughs) and really wanted to work with her and so yeah I remember that.</p> | <p>61. M3 describes an experience that she remembers clearly to exemplify this : a woman who she cared for on two different occasions. On the first occasion prior to meeting her M3 had an unpleasant rainy and dark journey travelling to see her. During her travel she thought she did not care or not whether this woman chose to work with her however when she got there she decidedly wanted to work with her.</p> | |
| <p>62. It was more than intuition you know it was her words, it was her demeanour, it was her personality so I just felt</p> | <p>62. M3 believes that this was a combination of intuition and the woman's words and items of conversation, her manner</p> | <p>62. M3 utilises her intuition alongside a woman's behaviour and communication.</p> |

| Meaning Units | Transformation 1 | Transformation 2 |
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| <p>you know that I understood who she was so it was more than intuition. It was, you know, it was the things she said to me</p> <p>63. Yeah so that was her first baby. So I'm going to tell you about her second baby now oh actually it was her second child, she'd already got a child when I met her.</p> <p>64. Her third labour which again maybe this would, I have to be a bit careful of confidentiality but (pause) I turned, actually no I'm going to go back because there is quite a bit of intuition in her first, in her second labour.</p> <p>65. Her first one with me she called me out to her,</p> | <p>and personality.</p> <p>63.M3 describes how this was the first occasion she met her however she wishes to describe the time when she was caring for her when she was expecting her 3rd baby.</p> <p>64.M3 considers the woman's historical details.</p> <p>65. M3 describes how when the woman went</p> | |

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| <p>quite early in the morning and when I got there, she wasn't in labour (pauses) but I felt and I the first labour I don't know how long it had been but anyway she'd had a normal birth first baby.</p> <p>66. But I mean she lived a long way away from me so this is all my decision making, but I knew she wasn't in labour (laughs) but she was dilated, she was quite dilated 9 (pauses) and I went into the town, the near town and just had a drink and a wander round and I knew not to be far away (laughs).</p> | <p>into labour</p> <p>she called her in the early hours of the morning and when she had arrived the woman wasn't in labour.</p> <p>The woman had experienced a normal first birth.</p> <p>66. M3 describes how the woman lived a long distance away from her and she knew she was not in labour although her cervix was quite well dilated, instead of returning home M3 intuitively knew to stay close by so she went and had a drink in the nearest town.</p> | <p>66. M3's intuition specifically informed her to remain in the locality of the woman's house.</p> |
| <p>67. And, but again it's clinical skills because she was quite dilated, she wasn't in labour, but she</p> | <p>67.M3 believes this experience was a mixture of clinical skills in terms that her cervix was well</p> | <p>67. M3's specific intuition was utilised alongside her clinical skills and was subsequently confirmed</p> |

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| <p>rang me and I wasn't far away at all and I got back and the baby was literally coming (both laugh) so, you know my instinct not to go far away was strong and right year so, but again clinical skills in there as well, but she wasn't in labour when I left her (laughs). So that was very interesting, that was you know very nice.</p> <p>68. The third child with me she rang me up. I think going back, sorry the second one she rang me up, she was very frightened actually and she was crying and she felt something was wrong and she needed, she just needed really, so I went you know for reassurance not because she was in</p> | <p>dilated although she was not in labour. The woman rang her again and this time the baby was about to be born. M3's intuition was very strongly informing her not to return home and stay close by which turned out to be correct.</p> <p>68. On this occasion M3 remembers that the woman had originally rung as she was tearful and frightened and wanted M3's presence and so her original aim had given comfort to the woman however late that day she gave birth.</p> | <p>as being correct.</p> |

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| <p>labour and ended up having the baby later that day, year.</p> <p>69. The third child she called me again not in labour but I don't know might I'm confusing the two but might maybe thinking something was wrong but wanting reassurance.</p> <p>70. She wanted I think what she said to me was she needed me to be there she thought she maybe she needed me to be there to go into labour because she knew she'd given birth so quickly the second time.</p> <p>71. So I duly turned up and felt her tummy and I</p> | <p>69. When the woman was expecting her 3rd baby she called M3 wanting comfort although M3 could not completely recall.</p> <p>70. The woman had called as she was worrying about giving birth on her own as her second labour had been so fast.</p> <p>71. When M3 arrived she examined her abdomen</p> | |

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| <p>don't do vaginal examinations routinely at all but I thought hmm, hmm something's different here do you mind if I examine you? 'because I didn't think I was feeling a head, I didn't think, I didn't think I was feeling anything.</p> | <p>and felt something unusual so she asked the woman if she could undertake a vaginal examination which was not her usual practice as she could not palpate a head or anything tangible.</p> | |
| <p>72. I don't know, I can't remember now, I didn't think anyway, I examined her and I thought the baby was breech and she wasn't in labour again (laughs) she wasn't in labour I can't remember, I think she must have been dilated to some extent because I thought I was feeling a breech .</p> <p>73. And so we talked about what she would do, what she wanted to do and she wanted to stay at</p> | <p>72. When M3 undertook the examination she thought the baby was in the breech position at this point M3 believes she was not in labour however she was dilated to some degree although she is not absolutely sure.</p> <p>73.Following discussion the woman decided to stay at home for the birth,</p> | |

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| <p>home and so I called a second midwife, or at some point I did, I had a second midwife come and I'd arrived there in the morning this baby wasn't born until evening, no, no she was fully dilated when I arrived (laughs). She was fully dilated I think or about fully, that's right but not in labour, no contractions and all day she wasn't in established labour.</p> | <p>so a second midwife was summoned and the baby was born in the evening even though she had been fully dilated when M3 arrived.</p> | |
| <p>74. And I did actually have moments of being quite anxious during that day, and my second midwife had experience of breech too, we both had some experience of breech and when I wobbled, she was calm and when she wobbled, I was calm and</p> | <p>74. Although she had some experience of caring for woman with breech babies she felt a little worried at some points during the day however her second midwife also had experience and when M3 worried she was calm and vice versa.</p> | |

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| <p>so we support supported each other.</p> <p>75. And she was contracting I think but she wasn't having regular contractions. She wasn't having a typical labour at all. And the couple actually reassured us and said this is like my other labour.</p> | <p>75. The woman's contractions were not regular and her labour was unusual however the woman and partner reassured the midwives that this labour was normal as far as the woman was concerned.</p> | |
| <p>76. You know, when we were scared or when I was scared, the Dad, I remember him saying, yeah, this is just what you do this is how, this is how you labour.</p> <p>77. And the baby was you know, absolutely fine, and eventually she had a normal birth, a breech</p> | <p>76. M3 relates how the woman's partner reassured her that the labour was normal for his partner.</p> <p>77. M3 describes how the baby was fine and how she had a normal breech birth and had a large baby</p> | |

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| <p>birth, a big boy, a very big boy (laughs) and so where's the instinct? The instinct you know well I mean it's not instinct but it's clinical skills, but you know, I felt that there was what, what's going on here? Do a vaginal examination, and then, you know this believing in her and a really weird labour. Because it wasn't really a labour at all. (Laughs)And she just gave birth beautifully.</p> <p>78. But anyway she gave birth very beautifully and yeah, quite a few wobbles along the way about going into hospital but she was she was very sure she was fine and wanted to be at home anyway.</p> | <p>boy. In terms of intuition it was a combination of things, clinical skills in terms of questioning a presentation and confirming it with a vaginal examination combined with a sense of faith in the woman particularly as the labour was very sporadic and not usual all culminating in a wonderful birth.</p> <p>78. The birth resulted wonderfully and despite a few anxieties over whether to transfer her to hospital the woman was confident and wanted a home birth.</p> | |

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| <p>79. And she had a really, I mean but she had a real religious beliefs and strengths that she was being looked she believes that she was looked after and he was looked after, so that, that was her strength that she knew she was in good hands (laughs) or that it would be, whatever happens, whatever she was sent would be ok.</p> | <p>79. The woman had strong spiritual beliefs and her faith enabled her to feel safe, and she believed that whatever happened would be all right.</p> | |
| <p>79. I have lots of instances one (pauses) thinking about that year. The other one was a woman who gave birth last year and she had a very long for her, a very long and difficult labour.</p> <p>80. She was a grand multip and she said it was the hardest of her labours</p> | <p>79.M3 describes another example when the woman had a very long labour comparatively to her other labours.</p> <p>80. The woman had had a number of other children and this labour for the</p> | |

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| <p>and it was very slow, and not what you'd expect for a grand multip I suppose.</p> <p>81. And although I know that often those labours are a bit odd and as the baby was being born I think it was happening quite slowly and my instinct was to tell her if it if the baby wasn't born, I wanted her to stand up.</p> <p>82. it wasn't a particularly long labour at all, a long birth, but I suppose it was I knew the baby was big, I knew she was overdue so again this clinical stuff going on I the background; I knew the baby was big, I knew she</p> | <p>woman was the most difficult. It was a slow labour which is uncharacteristic for a grand multip.</p> <p>81. M3 states how although she realises that these labours can be unusual she describes how during this birth which was somewhat slow, her intuition was informing her that she should tell the woman if the baby was not born soon she should stand up.</p> <p>82. Although the labour had not been that long, the birth was and M3 describes how she knew the baby was big and the woman was post dates which again was an assessment process of what was happening, the</p> | <p>81. M3's intuition specifically directed her to ask the woman to stand.</p> |

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| <p>was quite overdue, I knew that this was a I think it was seventh baby so I knew it ought to be coming quite quickly and it wasn't.</p> <p>83. But you know the heart rate had been fine, the progress was ok really but, but I had a very strong instinct that I needed her to move and yeah and she year that's right and she stood up and the baby was born but the baby was completely tangled in the cord.</p> | <p>woman was also a grand-multip so the baby should have been born quickly however this was not happening.</p> <p>83. Despite the baby's heartbeat and the progress of labour being normal M3 still had a really strong sense of intuition that the woman had to move, when the woman stood up the baby was born, however the baby was tangled in the cord</p> | <p>83. M3's intuition was confirmed as correct as her intervention enable the woman's birth to be expedited.</p> |
| <p>84. And was quite flat actually, much flatter than I would have expected because the heart rate had been fine, the progress and, I'm just trying to think what it was</p> | <p>84. M3 describes how the baby was slow to respond which was not what she had anticipated as the fetal heart rate had been fine as well as the progress, the baby, a girl</p> | <p>84. M3's intuition was confirmed to be correct and was utilised alongside her clinical skills.</p> |

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| <p>a little girl, she did need a little bit of resuscitation and, and I did call an ambulance so my instinct was absolutely right, to do something and that was that I acted much quicker than I would normally had done, and I don't quite know why I did but I guess you know as I've said to you there were several clinical things.</p> | <p>did require resuscitation and an ambulance was summoned, so again in this situation M3 believes her intuition was absolutely right to act more swiftly than she usually would have done. M3 is not completely sure why she did however does acknowledge there were several clinical cues.</p> | |
| <p>85. And I just had a strong instinct that I needed her to do something, so that was that one.</p> | <p>85. M3 describes how her intuition informed her to act.</p> | |
| <p>86. So yeah I think there is a lot of times when you don't quite know why you're doing something but you feel obliged, compelled to act.</p> | <p>86. M3 describes how there are many occasions where she does not always know why she has to act in a certain way however she feels forced to act.</p> | <p>86. Whilst the reasoning behind M3's remains tacit her intuition is utilised and is directional in nature.</p> |

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| <p>87. I cared for another couple who were expecting twins and when I first went I was unsure, I really felt a bit unsure how things about how our relationship would be, and they turned out to be wonderful so you know, I didn't say a 100%, I was a bit when I met them I felt, I'm not sure I should be taking these people. It was a really positive experience. It was just them as a couple or, or maybe even the woman, it was more the woman I think that I just wasn't sure.</p> | <p>87. M3 describes how she cared for a couple expecting twins, where she was not completely sure how their relationship would be. M3 describes however the couple turned out to be brilliant. M3 relates how she was not completely sure it would be a negative experience but wasn't completely sure she should work with the couple she wasn't sure whether it was the couple together or the woman that made the experience so good.</p> | |
| <p>88. I had a client last year again who I didn't think, a woman very emotionally complex woman, I didn't think she would give birth</p> | <p>88. M3 describes how she worked with a woman who was psychologically multifaceted, M3 did not believe she was going to</p> | |

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| <p>at all or easily at all she had a beautiful birth (both laugh) and there were issues afterwards, retained placenta and all sorts of other stuff but she gave birth beautifully. So the instinct isn't you know you have a feeling and you, but it's not always but it's not always right (pauses).</p> <p>89. I suppose it teaches me to be, not to have expectations not to be too judgemental about people because you know you have to be really open and believe in people because it's not always going to go how I might expect that it will, so I mean I try very hard to be to be open, but you can't help having those</p> | <p>birth normally however she had a wonderful birth despite some difficulties afterwards, M3 reflects how her intuition therefore is not always right.</p> <p>89.M3 relates how this sense of intuition has also informed her to not always trust it completely as it can cause her to criticise people or create expectations. M3 makes an effort to be receptive however cannot deny her sense of intuition.</p> | <p>89. M3 does not always utilise her intuition, at times her ethical knowing is prioritised.</p> |

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| <p>feelings.</p> <p>90. I wonder if my expectations affect the outcome and I you know I would really hate it if I'm less supportive or less encouraging but it's human nature, we can only do what we can do can't we?</p> <p>91.I mean you, you see it on labour ward all the time that midwives know a woman's going to have an instrumental delivery, but they still keep encouraging and being positive that she's going to have a normal birth.</p> | <p>90. M3 wonders if her sense of intuition and the expectations it sets up are a party to a woman's birth outcome , she finds it abhorrent if she was consequently less caring or encouraging however realises that intuition is part of her make up.</p> <p>91.M3 reflects how she sees similar events in the hospital when midwives realise that a woman will have an operative birth but remain hopeful and supportive.</p> | |
| <p>92. And I can't , I find that really hard to do because</p> | <p>92. M3 describes how her lack of enthusiasm and</p> | |

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| <p>I, if I think a woman's not going to give birth then, I think I give up a little bit and don't want to encourage her. It's not that I don't want to encourage her but I find it hard to not be honest and straightforward.</p> | <p>support in a situation is not because she is lithe to do this , more that it is based on a desire to be truthful to the woman.</p> | |
| <p>93. And so I do wonder if my expectation, might have an effect on the outcome, but it probably doesn't because I'm saying, you know there's a few women who I've expected not to do well and they do, so hopefully I don't let my thoughts cloud, but you know and I am worried about that.</p> | <p>93. Having reflected on whether she does make a difference to the outcome M3 also relates that on some occasions her intuition is not correct and the woman goes on to have a normal birth.</p> | |
| <p>94. I suppose this, this question of when women go into labour: I mean I</p> | <p>94.M3 reflects on when she does not want womens' labours to occur</p> | |

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| <p>have thought that, sometimes I really don't want women to go into labour because I've got something happening in my life, and I have had that thought, am I stopping them? Is it me that's stopping them? As if I've got this great power but, which I'm sure I haven't. But I have had that thought, you know, is it me that's stopping them labouring? And I'm sure that's rubbish but.</p> <p>95. I mean I have lots of clients who go overdue and I feel very relaxed about women going overdue, I'm not at all phased by that.</p> | <p>because she has an important personal life event and she wonders whether she is actually stopping them, although M3 questions this belief it still concerns her.</p> <p>95. M3 relates how she is never worried or affected if women go post-dates.</p> | |
| <p>96. And I have a client at the moment and I don't feel that. I saw her</p> | <p>96.M3 describes how she is currently working with a woman who asked her</p> | <p>96. M3's intuition specifically informs her when a woman's labour</p> |

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| <p>yesterday actually and she's sort of saying she's said you know when's it going to happen? As they always do and, and I said to her I don't think it's going to happen yet, I think you've got another week or so to go at least and that, I do have quite a strong sense.</p> | <p>recently when she would go into labour and M3 replied it would not be until at least another week, she describes how this is a strong intuitive sense.</p> | <p>will commence.</p> |
| <p>97. And I remember one of my recent clients, when I'm heavily on call I tend to sort of have clothes ready when I go to bed so I can just. And I didn't, I think it was the night she went into labour or the night before she went into labour that I put my clothes out and she was like ten days overdue but I hadn't even bothered to put clothes out because</p> | <p>97. M3 describes how she recently worked with a woman and when the woman was due and she had to respond immediately she customarily prepares her clothes when she goes to bed. On this occasion however she did not. It was not until the night she actually went into labour that she prepared her clothes. M3 relates how</p> | <p>97. M3's intuition enables her to prepare for a woman's labour commencing.</p> |

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| <p>of, and maybe that's because I was busy in my own life you know I'm not saying that but it's very interesting that I wasn't really expecting her to labour until she did (laughs).</p> | <p>this could have been that she was involved in her own personal life however she finds it thought provoking that she intuitively sensed when the woman was to go into labour.</p> | |
| <p>98. And that's not saying that I know when women are going to labour, I don't say I know but I usually have quite a strong sense that a woman is not going to give birth yet, sometimes it's wrong, sometimes I think ooh she looks ready and I have that.</p> | <p>98. M3 reflects how it is not that she knows exactly when women are going to labour more that she has a strong intuitive sense that a woman is not ready, however she does accept that this is not absolute.</p> | |
| <p>99. And I tell women sometimes, I say ooh you don't look ready or you know, I might say it, and I have, I do sometimes see</p> | <p>99. M3 discusses how on occasions some women appear ready to labour however on a subsequent occasion they do not</p> | |

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| <p>women who look ready and then next week they don't look ready.</p> | | |
| <p>100. And I am caught out, you know I sometimes I have women who give birth at 37 weeks and I'm thinking I'm nowhere near ready for them to give birth, and so what is it that makes a woman ready or me think that they're ready?</p> <p>101. And again you know the woman who I'm waiting for now, this is her fourth baby, her last three she'd been late for, so I'm obviously thinking she's going to do the same again.</p> | <p>100. M3 describes how on occasions women will birth before she considers them ready, and ponders what it is that enables women to be ready or for her to know.</p> <p>101. M3 describes how currently the woman she is on call for has been post dates for all her pregnancies so she reflects whether this intuitive sense is part of having this clinical assessment that there is the probability that she will</p> | |

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| <p>102. I have this theory that it's not my theory, it's a borrowed theory that tall women have longer gestations and she's very tall and maybe there's some science in that, maybe (coughs) they've got more room so you know their body can accommodate a longer gestation, who knows? Another colleague talks about when she palpates, she feels that the uterus is ripe she feels that it feels different and I can't say that I have noticed that, but maybe I'm internalising that without noticing.</p> | <p>again go post-dates.</p> <p>102. M3 discusses other's theories of why women go post term and how to judge this.</p> | |
| <p>103. I've no idea, and I often have this</p> | <p>103.M3 describes how she does not have this</p> | |

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| <p>conversation with women, I don't know what makes them look ready but I'm sure midwives, do other, have you heard other midwives say that? I'm sure that the midwives do sometimes say that women look ready or not.</p> | <p>knowledge or skill to inform her</p> | |
| <p>104. And I've no idea what it is we're seeing, so, again I think that's a mixture of intuition and observation and clinical skills and who knows?</p> <p>105. I've never had the instinct that I've needed to rush somebody to hospital, I've never had that, not without good clinical (coughs) clinical evidence (pauses). I'm</p> | <p>104. M3 concludes that this is a mixture of intuition and clinical skill that is informing her.</p> <p>105. M3 reflects how she has never had an experience where her intuition has been to transfer a woman to the hospital, certainly not without adequate clinical</p> | |

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| <p>sure I have felt, but I can't think of examples, you know, similarly to the one where I dashed down to (place name) in the morning.</p> <p>106. I'm pretty sure I have had clients that I've felt very concerned about but, but probably you know, no bad scenario played through. But there are sometimes you know an instant where I don't have a good feeling about things.</p> <p>M3 then asks the tape to be turned off.</p> | <p>rationale. She feels she has however where she has been moved to visit a woman.</p> <p>106. M3 relates how she has had some experiences where she had intuitive concerns however nothing happened and relates how on occasion she does experience a sense of intuitive foreboding.</p> | |