Storytelling in midwifery-time to value our oral tradition?
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“I think, because we are in a culture that doesn’t respect intuition and has a very narrow definition of knowledge, we can get caught into the trap of that narrowness. Intuition is another kind of knowledge-deeply embodied. It’s not up there in the stars. It is knowing, just as much as intellectual knowing. It’s not fluff, which is what the culture tries to do to it”.
(Judy Luce, homebirth midwife, cited in Davis-Floyd & Davis, 1996)

Background
A recent experience of sharing practice at a storytelling circle (developed as part of midwifery supervision at a local NHS Hospital Trust birth centre) illuminated the value of sharing stories with midwifery colleagues. Two positional interventions, known as the ‘hip dip’ and ‘side lying release’ (see http://spinningbabies.com/learn-more/techniques/) were used in a difficult and prolonged labour to encourage the baby to rotate from a persistent posterior to an anterior position and be born at home shortly after, as planned. This experience was shared with the midwives at the circle and the interventions were demonstrated and practised by the midwives present. Much discussion and reflection followed, primarily focused on how the techniques may have worked to relax the pelvic floor muscles and ligaments and create more potential for the baby to rotate into a favourable position for birth. The technique has particular relevance for standalone birth centres. Midwives practising in this environment are frequently faced with the dilemma of managing persistent posterior positions and prolonged labour, with no access to medical interventions such as augmentation of labour using synthetic oxytocin. A few weeks later, a midwife from the storytelling circle was excited to report that the techniques had been used successfully at the birth centre to correct a persistent posterior position, resulting in a spontaneous birth shortly after. She was particularly happy, as the use of the techniques had been a ‘last ditch’ attempt to avoid transferring the mother to the obstetric unit. I too felt delighted and intrigued that use of the techniques appeared to have positively influenced another prolonged labour situation. However, I also immediately started to question whether it was the effect of the intervention in both cases, or whether the babies had just spontaneously turned, as there was no ‘scientific’ evidence to support the use of the technique. In the days that followed, I started to question my cynical response. Why was I so quick to devalue the experiences of using the techniques as ‘unscientific’, when they appeared to have had such an immediate and positive impact on birth outcomes?

Ways of Knowing
There is extensive discussion in the literature related to the art and science of midwifery practice (Carper 1978, Davis 1995, Hagell 1989, Gilkison 2013, Power 2015). However, it is scientific ways of knowing that have come to dominate our society (Barnes 1999, Davis 1995, Davis-Floyd & Davis, 1996, Shallow 2001, Yuill 2012). This has had profound implications for the art of midwifery practice. The current dominant scientific discourse is prevailing, powerful and reductive (Foucault 1976, Fry 2007). Belenky et al (1986) describe how the current dominant ways of knowing (rational, masculine, technological, scientific) disadvantage women’s ways of knowing, which tend to be more emotional,
intuitive and personalised. Women have accrued and passed on knowledge about childbirth over many centuries and yet much of this knowledge is disregarded and devalued by the current dominant scientific discourses (Stewart 2010) and by midwives themselves. In addition, Schon (1983) suggested that professional education undermines knowledge gained from practical experiences and reflection, by valuing intellectual, scientific knowledge forms more highly. Central to knowledge discourses is the notion of power. Foucault (1980) describes knowledge and power as synonymous. Although several discourses will exist in any society at a given time, society decides and gives authority to particular discourses at the expense of others. Many feminist writers, indeed many midwives have challenged the authority of scientific knowledge in relation to pregnancy and birth, because it subjugates other ways of knowing (Murphy-Lawless, 1998). The personal experience described above is a perfect example of this process at work, where the value of a technique is questioned and then devalued in relation to the lack of empirical evidence to support it. And yet there was so much more going in in terms of the process underpinning the decision to use the techniques. Experienced midwives utilize other ways of knowing based on their practice experience. Hunter (2007) described the types of knowledge utilized in midwifery practice; these include scientific knowledge (the dominant discourse which has been described), intuitive knowledge and embodied knowledge. Intuition is defined by the Oxford English Dictionary as ‘The ability to understand something instinctively, without the need for reasoning’ (2016). Hunter describes embodied knowledge as informal knowledge learned from personal experience and observation of colleagues. The utilization of intuitive and embodied knowledge is at the heart of midwifery practice. Carper’s taxonomy of knowledge (1978) describes intuition as the basis for the art of nursing practice. Reflecting on the example given above, the decision to try techniques to correct the posterior position of a baby in labour was made based upon my own clinical experience of looking after women in labour in similar situations. The experience, described in the storytelling circle, utilized my embodied and intuitive midwifery knowledge of the critical relationship of the baby to the maternal pelvis in a posterior labour. The application of this knowledge drove the decision to try an intervention when all else had failed. Why had I not valued this complex knowledge and decision-making more highly?

**Midwifery knowledge**

Midwifery is a relatively new profession and has borrowed heavily from medicine and other health professions in constructing its own knowledge base (Hunter 2008). The impact of this ‘borrowed’ scientific body of knowledge is that the profession has ended up ideologically in conflict with itself (Wilkins cited in Kirkham, 2000). The scope of practice in midwifery is focused on normality in pregnancy and birth (NMC, 2013), with emotional care prioritised alongside physical care. The current dominant scientific paradigm, in which midwifery currently exists in the UK, has little to offer this model of care. If we accept the randomised controlled trial as the gold standard measure of scientific research (Stewart 2010) with particular emphasis on measuring the effect of interventions, it is clear that it has limited application to normal midwifery practice. Midwifery, in its purest form, is about non-intervention and is respectful and supportive of the physiology of pregnancy and birth. In direct opposition to the use and measurement of interventions in practice, the place of well judged non-intervention or ‘the art of doing nothing well’ has long been recognized in midwifery (Powell-Kennedy 2002, Anderson 2004) and is critical to facilitating normal birth outcomes.
Oral Culture
Rolfe (2000) suggests that nursing and midwifery is historically an oral culture, where the generation of knowledge and facts occurs through narrative or 'storytelling' rather than through scientific papers. He describes the work of the postmodernist philosopher Lyotard, who states that scientific knowledge is a relatively new concept when considered in relation to the tradition of narrative knowledge. He suggests that narrative knowledge is a legitimate alternative. In broad terms, scientific knowledge involves the transmission of facts from one who knows to one who does not and is generated via empirical research and publication. Narrative approaches can accommodate a much broader epistemology (Fry 2007) and involve the passing on of more diverse knowledge as in the manner of the storytelling circle. Interestingly, in relation to the oral culture identified, a number of practices in midwifery have seen widespread adoption prior to there being published research data to support them. These include the non-suturing of perineal tears during the 1990s, the use of water for labour and birth during the same period and more recently the use of hypnosis for birth. This supports the view that the narrative tradition of knowledge sharing in midwifery is still evident and has a widespread influence on practice. The storytelling group and the sharing of experiences are a typical example of this 'passing on' of knowledge.

Feminist Perspectives
We have briefly touched upon the way in which scientific knowledge disadvantages women’s ways of knowing. Feminist theory is concerned with the way in which gender influences our concept of knowledge and research practices (Anderson, 2005). Oakley (1990) identified that male orientated bias is inherent in scientific research, which is highly gendered with its roots in science and rationality. This in itself may have the effect of producing a limited and distorted epistemology of women. Standpoint feminism, which is a specific feminist theory, is focused on knowledge being explored from the standpoint of women and their experiences (Hartsock 2003). Standpoint feminism attempts to critique dominant conventional epistemologies and arguably, is highly appropriate for adoption into midwifery practice, research and the associated generation of knowledge. Yuill (2012) identifies that midwives claim to be autonomous professionals, but in reality their practice is oppressed by the use of quantitative research findings that are frequently used to direct and dominate the management of care in maternity services. This has the effect of marginalizing midwifery knowledge. Keating and Fleming (2007) capture this perfectly in their research investigating midwives’ experiences of facilitating normal birth in an obstetric unit, where midwives regularly navigate a sea of competing obstetric and midwifery ideologies. The midwives in the study identified that greater value was placed upon midwifery practice incorporating intuitive and experiential knowledge on night duty (when it is predominantly labouring women and midwives who are present), compared with day shifts where this knowledge was devalued in favour of technology. This reflects my own experience of midwifery practice and illuminates the process that I described earlier, where the devaluing of intuitive, embodied knowledge occurred in favour of the perceived need for a more rational, scientific evidence base.

Narrative Approaches and Midwifery
Let us come back to the starting point of this work, the storytelling circle. We have learned that historically, midwifery is an oral culture. There is evidence that the process of passing on knowledge and experience in midwifery orally (rather than via empirical research and publication) persists. The oral tradition is ingrained in the processes of the storytelling group, with the sharing of intuitive, embodied, experiential knowledge. This is underpinned with feminist epistemology, which is focused on knowledge
being explored from the perspective of women and their experiences. We have identified that the prevalent scientific discourse, which subjugates midwifery knowledge, is a poor fit in terms of providing a relevant knowledge base for the practice of midwifery. If the profession is to develop an appropriate knowledge base then new approaches to research and education must be identified. Walsh and Evans (2013) state that despite the growth of midwifery research over the past twenty years, discussion and debate regarding the philosophical underpinning of research methods has been conspicuously absent. This needs urgent attention if midwifery as a profession is to progress the generation of an appropriate body of professional knowledge.

The storytelling circle, which has been explored in relation to midwifery discourse and knowledge, is a good example of the use of narrative. Narrative pedagogy is defined as an approach to thinking about teaching and learning that evolves from the lived experiences of teachers, clinicians and students (Nehls 1995). Narrative inquiry is an umbrella term that captures the personal and human dimensions of experience over time and takes account of the relationship between individual experience and cultural context (Clandinin and Connelly 2000). Narrative inquiry is based upon social constructivist, constructivist and feminist principles, where stories of lived experience are co-constructed by those involved. The process of narrative inquiry captures complex, multi layered information that can be used to inform practice (Diekelmann 1995). Polkinghorne (1995) describes stories as socially situated knowledge constructions that value the complexity, depth and texture of real life experience.

There is some literature on the use of storytelling or narrative as a tool within education (Davidson 2004, Haigh & Hardy 2011, Schwartz & Abbot 2007, Weston 2012). However, it is generally used to encourage students to appreciate alternative perspectives, for example, those of service users and to connect theory to practice and facilitate reflection. Storytelling as a tool is different from the broader use of narrative as a strategy for teaching or research. There is very little literature on the use of narrative pedagogy or inquiry in relation to midwifery, which is surprising. As we have seen, experiential knowledge underpins midwifery, and the generation of knowledge via the sharing of stories from practice is not uncommon. Narrative approaches to education and research capture the essence of this by focusing on social reality, lived experience, complexity of practice and the co-construction of knowledge (Clandinin & Connelly 2000).

**Conclusion**

The professionalization of midwifery is a relatively recent development with the move into higher education institutions and the generation of midwifery knowledge via research. As a result, the profession has borrowed heavily from medicine and other health professions in constructing its own knowledge base (Hunter 2008). The time may have come to recognize the limitations of the randomized controlled trial on midwifery practice, which in its purest form, is about enabling physiology. The practice of midwives passing on experiences via storytelling as a legitimate knowledge form is supported by feminist philosophy. Midwives should be encouraged to value this ‘way of knowing’ more highly. In addition, more research in the context of UK midwifery practice should be undertaken to develop the knowledge base. The use of narrative as a strategy for developing midwifery education, research and professional knowledge has been explored. Although biomedical knowledge is, of course, critical to high quality midwifery practice, narrative pedagogy and inquiry has the potential to further develop the art of midwifery practice via the generation of knowledge that is potentially highly relevant to the profession. There is data that suggests narrative approaches may enhance and develop insight, empathy, connectedness and intuition (Davis-Floyd 1996, Fry 2007, Hunter 2008), skills that are at the very centre of excellent, woman-centred midwifery practice. This may contribute to enabling midwives to
develop a relevant and powerful discourse that isn’t borrowed from others. Isn’t it time we consider this this as a profession and give equal value to alternative ways of knowing? In doing so, we may finally feel able to validate the oral tradition at the heart of midwifery practice.

References:


