

Article of the month

Storytelling, midwifery knowledge and physiological birth

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Midwifery has a long oral tradition, where knowledge has been generated via the sharing of stories and experience from practice, rather than via scientific research. Any midwife working in a team in the community, on a labour ward or in a birth centre will be familiar with the rich discussion and reflection on practice that is at the heart of what we do. In recent years, the move towards a more scientific and 'evidence-based' approach has undermined the value of this tradition as a form of knowledge.

This article explores the nature of midwifery knowledge, proposing that storytelling is a valid method of sharing, reflecting on and developing midwifery knowledge and practice in relation to supporting physiological labour and birth.

Oral culture in midwifery

Historically, nursing and midwifery have an oral culture, where knowledge is generated through narrative – or 'storytelling' (Rolfe 2000). Rolfe describes the work of Jean-Francois Lyotard, a postmodern philosopher, who stated that scientific knowledge is a relatively new concept compared with narrative knowledge, but that both are legitimate ways of knowing. This culture may go some way to explaining the loss of women's experience in history and in society. This is a well-documented phenomenon, recently described by Criado-Perez (2019) as a 'gender data gap'.

The invisibility of women in history includes midwifery. There are rare exceptions. The **stories of elderly midwives and 'handywomen' were captured** by Leap and Hunter **in *The midwife's tale*** (1993), which otherwise would have been lost in time. Midwives delight in reading the accounts in Leap and Hunter's book: they recognise much of their own experience in the storytelling drawn from practice. A recent reflection on the novel *The handmaid's tale* (Attwood 1985), which traces the loss of women's rights in a male-dominated totalitarian dystopia, resonated with this oral tradition and loss of women's history. At the very end of the story, an account of the central (female) character's life in Gilead is discovered 200 years on. It is not written or published, but recorded on an audio cassette almost lost in time, like much of women's history.

Ways of knowing

Observations via storytelling, of the nuances of labour and birth, are extremely common in midwifery practice. There are so many things that midwives 'know' or 'feel' via their shared experience and discussion of physiological birth: the psychology of women 'holding on' to their babies in late pregnancy, only starting labour when they have sorted their toddler out and feel ready to birth; the natural slowing down of contractions at the end of the first stage of labour in primigravid women, often termed the 'rest and be thankful' phase, which frequently occurs before the hard work of expulsive labour begins. The list is long and represents what midwives collectively 'know', yet **so many of these things are almost impossible to research using scientific research methods**. In addition, very little published evidence exists in relation to these phenomena. So how *do* midwives 'know' these things?

Hunter (2008) described the multiple forms of knowledge used by experienced midwives, which include scientific knowledge but also intuitive and embodied knowledge. The latter two are drawn from instinct, personal experience and observation of colleagues. So, as in the examples given above, midwives reflecting on and sharing their experiential knowledge and techniques for practice via the telling of stories, is a legitimate 'way of knowing'.

Storytelling, practice development and women's knowledge

The sharing of this knowledge via the process of storytelling is likely to be at least partly responsible for a number of practices that became commonplace before widespread published evidence to support them existed. Examples include the use of water for labour and birth, non-suturing of perineal trauma, and hypnobirthing. The recent experience of a nearby freestanding midwifery unit (FMU) demonstrates how women and midwives sharing stories leads to changes in practice. Opening in 2013, the FMU numbers were very low, and local women were quite mistrustful of the concept of a midwifery unit without medical back-up on site. Over time, the midwives have facilitated the sharing of the women's birth stories via social media and have employed strategies to encourage women into the unit, enabling them to socialise via normal birth classes, antenatal care, to access breastfeeding support and so on. The midwives have seen the number of births at the unit increase dramatically, and feel certain that the phenomenon of women sharing their positive experiences has had a huge impact on this, assuring the viability of the unit and positioning it as a vibrant community hub, in line with the vision set out by NHS England (2016**REF NEEDED IN REFS LIST PLEASE**).

The passing on of knowledge from midwife to midwife and/or woman to woman regarding practices found to be effective for childbirth is likely to have contributed to this. After all, **women have been gathering and passing on knowledge related to pregnancy and birth for centuries**, yet much of this

knowledge is disregarded and devalued by the dominance of more scientific forms of knowledge (Stewart 2010). The dating scan is a perfect example where technical, scientific information trumps women's intimate knowledge of their own bodies. The setting of an estimated date of birth (EDB) via ultrasound scan, is often at odds with the one calculated using information generated via the woman's knowledge of her menstrual cycle, date of ovulation or conception. The woman's own EDB is overruled by the technical calculation generated by the scan. Belenky et al (1986) describe how current, dominant ways of knowing (rational, masculine, technological, scientific) disadvantage women's ways of knowing, which tend to be more emotional, intuitive and personalised. This devaluing of women's knowledge has also been compounded by the rise of professional academic education, which has a tendency to undermine knowledge gained from practical experience, by placing higher value on intellectual and scientific forms of knowledge.

Scientific research and physiological birth: a poor fit?

The experiential, intuitive and embodied knowledge underpinning midwifery practice, has been sidelined in recent years by the higher value placed on scientific knowledge. This is epitomised by the rise of evidence-based practice, where evidence generated via formal research is ranked in a hierarchy based on scientific rigour. 'Gold-standard' evidence, at the top of the hierarchy, is generated using quantitative research methods, such as randomised controlled trials (RCTs), which test treatments or interventions in a population. Sometimes this evidence is pooled via systematic reviews (such as Cochrane), which provide evidence in relation to very specific research questions. Case studies and expert opinion are at the bottom of the evidence hierarchy. RCTs and systematic reviews are generally of limited value to midwifery practice, which is not primarily focused on treatments or interventions, but on supporting and optimising the physiological processes of pregnancy, labour and birth (The Lancet 2014). And **in physiological labour and birth, when things are progressing, minimal intervention is required**. It has been proposed that 'the art of doing nothing well', by supporting the normal process of labour and birth with vigilance and attention, is at the heart of midwifery practice (Kennedy 2000). It is extremely hard to measure this skilful vigilance using scientific research methods such as RCTs. Yiull (2012 **REF NEEDED IN REFS LIST PLEASE**) supports this position, arguing that midwifery practice is completely oppressed by the use of quantitative research findings, which are frequently used to direct and dominate the management of care in the maternity services.

Labour, birth and 'unique normality'

The limitation of largely scientific approaches to generating knowledge for midwifery practice is compounded by the fact that each labour and birth is a complex and individual process, affected by many factors that are difficult to

measure and quantify via the narrowly defined focus of a typical RCT. A recent, large cohort study concluded that it is impossible to predict birth outcomes for mothers and babies via simple linear measurement of rate of progress in labour because of the high level of natural variability inherent in the process (Oladapo et al 2018). Downe identifies this complex variation between labouring women as 'unique normality' (Downe 2004), arguing the case for a move towards a new knowledge base for midwifery that embraces this variation.

The slow decline of physiological birth

How can midwives start to meet the need for evidence that is a better fit for their practice? This need is an urgent one: the recently published *National maternal and perinatal audit* (NMPA) suggests that physiological birth is declining, year-on-year. The spontaneous UK birth rate, without intervention, stands at a shocking 36.9 per cent (NMPA Project Team 2019). And just like *The handmaid's tale*, where women sleepwalked into the loss of their reproductive and human rights, it feels as though midwifery is going down the same path. We are witnessing the loss of something uniquely valuable to women, babies, family and society. The generation and promotion of midwifery knowledge must be at the heart of a concerted action to reverse the declining trend in physiological birth. And to be absolutely clear, this is not about the self-interest of the profession. We serve women, babies and families. Recent research by Downe et al (2018), demonstrates that the majority of women want a physiological labour and birth. We are currently failing them.

Taking the lead: developing a new knowledge base

Midwives are perfectly placed to generate the insight required to develop the type of knowledge that is currently lacking but very much needed, to support and strengthen the rate of physiological birth. They are the experts in this field (and no-one else). They must find ways to lead on this, to dictate the research agenda.

Narrative research (the academic terminology for storytelling) is a good fit and should play a part in this, even if only to kick-start some other more conventional methods of enquiry. Midwifery storytelling circles in every NHS trust in the UK could be the start of this process. Midwives know exactly what research and evidence are needed to develop their knowledge and skills in relation to optimising labour and birth physiology. Experience at a FMU storytelling circle triggered discussion of the potential of 'spinning babies' techniques to address fetal malposition occurring in labour. The subsequent informal use of these techniques seemed to make a difference in some of those labours, reducing the need to transfer for slow progress. This is a good example of midwives sharing insights and 'tips' based on their experiential

knowledge. Protecting midwife-time to do this in a more formal way will be a challenge, but it is something that may begin the process of generating grass-roots knowledge to optimise the skills required to support physiological labour and birth. If this is our priority as midwives, we have no time to waste. **TPM**

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