

**Straddling Paradigms: An interpretive hermeneutic  
exploration of midwives practising homeopathy**

**by**

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A thesis submitted in partial fulfilment for the requirements for the degree of  
PhD at the University of Central Lancashire

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## STUDENT DECLARATION FORM

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution

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## Abstract

This study aimed to explore the experiences of midwives who were also homeopaths as they attempted to straddle the different philosophical and practice paradigms they encountered in each domain. It also explored the implications of their experience on their practice. Over recent decades the National Health Service (NHS) has moved towards a scientific-bureaucratic perspective, in which the emphasis is on the use of evidence-based frameworks. It has been argued that this development has moved the focus in healthcare away from '*caring*'. In parallel, there has been an increase in the demand for complementary and alternative medicines in the United Kingdom (UK), and elsewhere. In responding to this call a number of midwives have taken up training opportunities in massage, aromatherapy, hypnotherapy, acupuncture and homeopathy, amongst others. There are no studies however, that have examined the impact of training as a homeopath on midwives and their practice. After a comprehensive analysis of existing literature, this study used an interpretive hermeneutic framework to explore the experience of midwives who trained as homeopaths. In-depth interviews were conducted with seven midwife homeopaths. The findings were analysed using three different lenses. The first of these conceptualised and explored the midwives narratives as personal and professional metamorphoses, as they changed from midwife to homeopath or midwife homeopath. Secondly, the data were framed using a Heideggerian lens, which illuminated a process of transformation into being authentic practitioners. This demonstrates how authenticity allowed the participants to (re) engage with, and further value the therapeutic relationship as a fundamental element of their clinical practice. The final lens explored the impact engendered of being authentic on the therapeutic relationship that developed between midwife homeopath and the women in their care. The conclusion was drawn that the therapeutic relationship developed by an authentic practitioner via a

homeopathic consultation is transferable to other healthcare practitioners, and offers a challenge to practice based in notions of scientism and bureaucracy. Further exploration of these phenomenon's could help to deliver on the drive to deliver compassionate personalised care across the NHS as a whole.

## Table of Contents

<b>Student Declaration .....</b>	<b>Error! Bookmark not defined.</b>
<b>Abstract .....</b>	<b>3</b>
<b>List of Tables and Figures.....</b>	<b>11</b>
<b>Acknowledgements .....</b>	<b>13</b>
<b>For Dad (Two Ways of Looking at a Death).....</b>	<b>14</b>
<b>Guide to abbreviations .....</b>	<b>15</b>
<b>Section One: Introduction, Background and Review of the Literature. ....</b>	<b>17</b>
<b>Chapter One: Introduction.....</b>	<b>18</b>
<b>1.1 Introduction .....</b>	<b>18</b>
<b>1.2 Why this research?.....</b>	<b>18</b>
1.2.1 Personal motivations for the study.....	19
1.2.2 Professional motivations for the study.....	20
<b>1.3 Framing the research: A crisis in healthcare.....</b>	<b>23</b>
<b>1.4 Research question.....</b>	<b>28</b>
<b>1.5 Structure of the thesis.....</b>	<b>28</b>
<b>Chapter Two: Background and key debates in the professions. ....</b>	<b>31</b>
<b>2.1 Introduction .....</b>	<b>31</b>
<b>2.2 Historical development of midwifery .....</b>	<b>31</b>
<b>2.3 Characteristics of late 20<sup>th</sup> and early 21<sup>st</sup> century UK midwives.....</b>	<b>42</b>
<b>2.4 The role of the midwife .....</b>	<b>44</b>
<b>2.5 Philosophies of maternity care in the 20<sup>th</sup> and 21<sup>st</sup> centuries .....</b>	<b>45</b>
2.5.1 Technocratic philosophy of childbirth.....	46

2.5.2 Social philosophy of childbirth .....	47
<b>2.6 Influences on maternity care in the United Kingdom .....</b>	<b>49</b>
2.6.1 Risk.....	51
2.6.2 Choice .....	54
<b>2.7 Introduction to homeopathy .....</b>	<b>56</b>
2.7.1 Philosophy underpinning homeopathy.....	57
<b>2.8 A brief history of homeopathy .....</b>	<b>58</b>
<b>2.9 Types of homeopathy .....</b>	<b>62</b>
<b>2.10 The homeopath.....</b>	<b>66</b>
<b>2.11 Evidence-based medicine .....</b>	<b>67</b>
2.11.1 Emergence of Evidence Based Practice .....	69
2.11.2 Midwifery and evidence-based practice.....	69
2.11.3 Critique of Evidence Based Medicine/Practice .....	71
2.11.4 Homeopathy and evidence-based medicine .....	76
<b>2.12 Conclusion .....</b>	<b>85</b>
<b>Chapter Three: Focused review of studies of homeopathy and midwifery.</b>	
.....	<b>87</b>
<b>3.1 Introduction .....</b>	<b>87</b>
<b>3.2 ‘Doing’ a mixed-methods systematic review in a phenomenological study?</b>	
.....	<b>87</b>
<b>3.3 The importance of the literature review .....</b>	<b>88</b>
3.3.1 Locating relevant papers.....	90
<b>3.4 Results .....</b>	<b>93</b>
3.4.1 Attitudes and use of homeopathy by midwives and women.....	101
3.4.2 Summary of the key points .....	118
3.4.3 Trials of homeopathy in maternity care.....	120
<b>3.5 Homeopathy: a complex intervention.....</b>	<b>137</b>

3.6 Conclusion .....	141
<b>Section Two: Data Collection.....</b>	<b>144</b>
<b>Chapter Four: Theoretical perspective and methodology.....</b>	<b>145</b>
4.1 Introduction .....	145
4.2 Aim of the study .....	146
4.3 Ontology and Epistemology .....	146
4.4 Objectivist or Subjectivist.....	147
4.5 Interpretivism.....	150
4.6 Phenomenology .....	154
4.7 Hermeneutics (the hermeneutic circle) .....	159
4.8 Conclusion .....	160
<b>Chapter Five: Study Design and Methods .....</b>	<b>162</b>
5.1 Introduction .....	162
5.2 Methods.....	162
5.21 Sampling: Participants and setting.....	162
5.22 Ethical issues .....	166
5.23 Confidentiality.....	168
5.24 The interviews .....	168
5.25 The phenomenological question .....	169
5.3 Data analysis .....	172
5.3.1 Introduction to the interpretive lenses .....	175
5.3.2 Trustworthiness of the data.....	179
5.4 Conclusion .....	180
<b>Section 3: Findings.....</b>	<b>181</b>
<b>Chapter Six: Findings: Metamorphosis to midwife homeopaths.....</b>	<b>182</b>

<b>6.1 Metamorphosis to midwife homeopaths .....</b>	<b>182</b>
<b>6.2 Introduction to the participants .....</b>	<b>182</b>
<b>6.3 'Blissful innocence' .....</b>	<b>189</b>
6.3.1 'Before the transformation' .....	189
<b>6.4 'From a little spark may burst a flame' .....</b>	<b>191</b>
6.4.1 'Hatching' .....	194
6.4.2 'Voracious appetite' .....	197
<b>6.5 'Cocooning' .....</b>	<b>198</b>
6.5.1 'Changing' .....	198
6.5.2 'Watching me' .....	201
6.5.3 'Hiding' .....	205
6.5.4 'Struggle' .....	205
6.5.5 'Restricting my autonomy' .....	208
6.5.6 'Adapting' .....	210
<b>6.6 'From Cocoon to Butterfly' .....</b>	<b>211</b>
6.6.1 Homeopathy and midwifery .....	212
6.6.2 'It's the way that you practise' .....	214
6.6.3 'Putting something back' .....	218
<b>6.7 Discussion .....</b>	<b>220</b>
<b>6.8 Conclusion .....</b>	<b>223</b>
<b>Chapter Seven: Returning to Heidegger .....</b>	<b>225</b>
<b>7.1 Introduction .....</b>	<b>225</b>
7.1.1 'Becoming' .....	226
7.1.2 Mood (Befindlichkeit) .....	230
7.1.3 Understanding (Verstehen) .....	232
7.1.4 'The They' (Das Man) .....	233
7.1.5 The Call .....	237



7.1.6 The Clearing (Lichtung) .....	241
7.1.7 Summary .....	243
<b>7.2 Autonomy .....</b>	<b>244</b>
<b>7.3 Conclusion .....</b>	<b>250</b>
<b>Chapter Eight: Viewing data through the lens of the therapeutic relationship.....</b>	<b>253</b>
8.1 Introduction .....	253
8.2 'Taking the Case' .....	261
8.3 'Connections' .....	264
8.4 Exploring the Journey Together.....	265
8.5 Finding the Level.....	266
8.6 Responding Therapeutically .....	267
8.7 Understanding Self.....	268
8.8 The importance of the therapeutic relationship.....	269
8.9 Synthesis of practice implications.....	275
8.10 Conclusion .....	278
<b>Chapter Nine - Discussion and Conclusions .....</b>	<b>279</b>
9.1 Introduction .....	279
9.2 Strengths and limitations of the study.....	287
9.3 Implications for practice.....	290
9.4 Suggestions for future research. ....	290
<b>Chapter Ten: Reflections and reflexivity .....</b>	<b>292</b>
10.1 Introduction.....	292
10.2 My experience of the study.....	293
10.3 Conclusion .....	297
<b>References .....</b>	<b>298</b>

<b>Appendices .....</b>	<b>325</b>
<b>Appendix 1: Alternative analytical frameworks .....</b>	<b>326</b>
<b>Appendix 2: Ethical approval letter (University of Central Lancashire). .....</b>	<b>331</b>
<b>Appendix 3: Participant information sheet.....</b>	<b>333</b>
<b>Appendix 4: Participant consent form .....</b>	<b>336</b>
<b>Appendix 5: Schedule of questions.....</b>	<b>337</b>
<b>Appendix 6: 6 C's of Compassionate Care.....</b>	<b>338</b>
<b>Appendix 7: Literature search document .....</b>	<b>341</b>
<b>Appendix 8: CASP Example.....</b>	<b>342</b>
<b>Appendix 9: Example of interview data.....</b>	<b>348</b>
<b>Appendix 10: Overview of themes.....</b>	<b>354</b>
<b>Appendix 11:Relationship of themes to Heideggerian concepts.....</b>	<b>355</b>

# List of Tables and Figures

## Tables

Table 1: Comparison between the technocratic and social philosophies of childbirth.....	48
Table 2: Systematic reviews of homeopathy (1991-2005).....	80
Table 3: Inclusion and exclusion criteria for the study.....	93
Table 4: Literature on homeopathy in pregnancy, childbirth and postpartum.....	100
Table 5: Studies examining attitudes towards the use of CAM in UK hospital settings.....	102
Table 6: Clinical studies of homeopathy in pregnancy, childbirth and postpartum.....	121
Table 7: Alternative Philosophical Paradigm Names.....	149
Table 8: Philosophical assumptions underlying the research paradigm.....	150
Table 9: Relationship between epistemology, theoretical perspectives, methodology and research methods.....	153
Table 10: Initial development of themes.....	177
Table 11: Current professional practice of participants.....	183

## Figures

Figure 1: The health & care system from April 2013.....	25
Figure 2: Shropshire Health NHS Library Levels of Evidence in Healthcare.....	68
Figure 3: Percentage of treatments likely to be beneficial.....	74
Figure 4: Literature search strategy.....	94
Figure 5: Circle of Methods in Research.....	140
Figure 6: Themes and subthemes in the study.....	188
Figure 7: Qualities, values and attitudes of midwife homeopaths.....	277
Figure 8: Diagram showing the tensions surrounding homeopathy and the NHS .....	282
Figure 9: Process of Data Analysis.....	176

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Finally, to my husband Peter, and children, Aisling and Greg, and daughter-in-law Hayley, thank you for always being there for me.

## For Dad (Two Ways of Looking at a Death)

the overworked doctor squirms  
when remembering  
that we are  
the Soon-To-Be-Bereaved

but he's fettered  
by protocol and the guidelines  
held close to his chest  
in an unnamed blue folder

he's visibly sinking  
under targets unmet,  
he needs to discuss harvesting organs,  
but knows that none can be used,

except for the skin  
the well worn, well creased,  
sun-savaged skin of an old man -  
his stock sympathies seem stale

II

A triangle of grief  
touches the arm, shoulder, hand  
of the man – Our Father.  
Quiet prayers intoned from a psalter, muffle  
the insistent blinks and bleeps of inevitability.  
Time suspends, bends in slow refraction  
brings his life to a single dot  
on a silent monitor.  
Then, a nurse's nod, a murmured sough,  
a sigh, and finally, that gentle lifting.

**Sue Morgan**  
2010

## **Guide to abbreviations**

AMU	Alongside Maternity Unit
CAM	Complementary and Alternative Medicine
DH	Department of Health
EBM	Evidence-based Medicine
FMU	Freestanding Maternity Unit
HMA	Homeopathic Medical Association
ICM	International Confederation of Midwives
MW	Midwife
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
OU	Obstetric Unit
RCM	Royal College of Midwives
RCOG	Royal College of Gynaecologists
SOH	Society of Homeopaths
TR	Therapeutic Relationship
UCLan	University of Central Lancashire
UK	United Kingdom
WHO	World Health Organisation





## **Section One: Introduction, Background and Review of the Literature.**

# Chapter One: Introduction

## 1.1 Introduction

The purpose of this interpretive hermeneutic study was to explore the experience of midwives who had also trained as homeopaths, and analyse the impact that training as a homeopath had on them and their practice. In this introductory section I consider the reasons for undertaking this research and take the opportunity to reflect on my own biography and uncover its relationship to the research. I then briefly situate the research within an NHS framework and its competing demands. This chapter concludes by providing an outline of the thesis.

## 1.2 Why this research?

Being reflective and reflexive are both purposeful activities in the evolution of any doctoral candidate. They assist the researcher in maintaining momentum in the study, however being reflexive also helps to '*legitimise, validate, and question research practices and representations*' (Pillow 2003, p.175). Pillow notes how reflexivity has developed as an important methodological tool in the research process. Embracing a reflexive approach allows the researcher to focus on questions such as '*how does who I am, who I have been, who I think I am, and how I feel, affect the data collection and analysis*' (Pillow 2003, p.176). This statement acknowledges that '*how knowledge is acquired, organised, and interpreted is relevant to what the claims are*' (Altheide & Johnson 1994, p.486). Cousins (2009, p.18) calls this process '*researcher positionality*'. Therefore, I believe that it is important to commence the study reflecting on my own place in this study, and how this impacts on the topic chosen, design of the study, collection and interpretation of the data. I start with describing my personal and professional motivations for undertaking the study before sharing excerpts from my research diaries.

There are a multitude of reasons, both personal and professional, why I chose to research this topic. My own encounter with pregnancy and birth was as a mother and a homeopath working with women who were either hoping to become pregnant, were pregnant or who had recently given birth. Here, I reflect on some of these reasons, as doing so explains my motivation for conducting the research.

### **1.2.1 Personal motivations for the study**

As an expectant mother almost 30 years ago, my experience was not a particularly pleasant one. I felt disempowered by the whole process of giving birth. It was a long labour, and I felt that I was left alone much of the time in a small anonymous room, being made to lie on my back. When the midwife did attend, she told me that the labour pain I was experiencing was not as bad as I thought it was. My subjective feelings did not appear to count for very much. What appeared to be more important to her were the objective signs of progress (or the lack of it). The midwife went so far as to threaten me with a '*forceps*' delivery, including a graphic account of the effect of it on my baby, if I '*didn't get a move on*'. Afterwards, I was told that she did this as she found that threats of this type often worked to start things moving. My diary entries at the time of writing my proposal reveal the influence exerted by this experience, it is a part of me and as such I have to acknowledge and work with it in this study. When remembering this birth I wrote:

*'Two weeks before I had my daughter I moved from Oxfordshire to York. I knew no one in York, it felt alien as though I had been transported to another country. I was 24. The night of my daughter's birth my husband was away on business. It was late and I was in bed, in an unfamiliar house, not home yet. My water's broke. I wondered what to do, I had no friends or family nearby. I rang the hospital, they said it was my first baby and to wait to go in when my contractions were every 5 minutes. I said I was on my own, they didn't say I should go in; they said to wait till family arrived or call the ambulance when the contractions were closer. I was scared and rang my husband who said he would come home, but it would take a few hours to get to me. Those 3 hours felt more like 24. I felt alone, and in pain, worried about what to expect during the birth. When he got home we went to the*

*hospital. My contractions were now coming every 3 or 4 minutes. They admitted me and put me straight into a delivery room, where I remained until my baby was born 12 hours later. They came in occasionally to 'do things', not to be there for me. It was cold and clinical, I felt surrounded by machines. I felt unsupported, as though I was a hindrance to them (the midwives), it seemed to me as though they felt they had better things to do than be with someone that wasn't 'trying'. Then when they threatened a 'forceps' delivery for mothers who didn't try I felt I had let both myself, and my baby down. Even thinking about my birth experience is visceral, and I start to think about how it could be different, to deconstruct it, and replay it with me as I now am, and with my 'ideal' midwives.'*

It was only when writing my research diary that I realised that I did, indeed, have a view of an '*ideal*' midwife. She, or he, would be technically proficient (that would be a given), but they would also be with me throughout, supporting me and also acting as an advocate for the birth I wanted. I had a birth plan, but because it had been developed during my time in Oxfordshire it was ignored, and I wasn't confident enough to challenge their actions. I definitely felt that they believed they '*knew best*' and I became a passive recipient of their care. This picture of the '*ideal*' midwife as competent, caring, supportive and listening stays with me as I write. It remains as a background to my narrative as I write my proposal.

### **1.2.2 Professional motivations for the study**

I qualified as a homeopath from a Society of Homeopaths (SOH) recognised college in 1997. Since obtaining membership of the Society of Homeopaths I taught homeopathy at both undergraduate and postgraduate levels in private colleges and universities as well as maintaining a small private practice. Previously a lawyer teaching mainly commercial law, I had at various times also worked with adults with special needs. As I studied and practiced homeopathy I found that many of my previously developed skills proved useful and helped shape the clinician I became. This was not only true for me but also reported by others on my four-year part-time

diploma course. One group of students I trained alongside particularly intrigued me. They were already statutorily registered health professionals, and I often wondered why they wanted to train as homeopaths. Through the process of journaling, I started to remember their stories. I remember feeling dismayed, and at times angry, when they struggled to garner support or attain recognition for what they were doing. Similarly, I felt delighted when they achieved recognition, or were able to influence some aspect of practice. This interest was rekindled when as the course leader for a BSc (Hons) Homeopathic Medicine I received applications from nurses and midwives.

It was when studying for a Master's degree in Holistic Approaches to Health that I had the opportunity to explore the interest expressed by nurses in complementary and alternative medicine. At that time my research focused on the knowledge base held by nurses, their previous training in complementary and alternative medicine, and whether they treated or referred patients to complementary and alternative medicine (CAM) practitioners. This small-scale research suggested that a high percentage of nurses in the study had an awareness of homeopathy and other CAM's (Duckworth 2003). The research also revealed that several nurses were happy making specific clinical recommendations to patients whilst remaining unqualified in that discipline. Around the same time (2000-2003) I was appointed to the post of Professional Conduct Director on the Board of Directors of the Society of Homeopaths, and one of the issues of concern raised was what should happen when a complaint was made about a practitioner holding dual registration. The question over which professional body's interests took precedence arose many times. Concurrently, as a homeopath in general practice I saw quite a few women during their pregnancies. Some mothers were existing patients, however, other mothers came to me for the first time, wanting help with their pregnancy, or wanting

to know which remedies they could use in labour and afterwards for themselves and their babies. This usually meant discussing the mother's previous birth histories and suggesting remedies that could be used, together with providing instructions for their use. The remedies would then be either self-administered or given by the woman's birth partner. The main reasons cited by these mothers for choosing homeopathy appeared to centre on the desire for a '*normal birth*' with as little medical intervention as possible, a position that I felt comfortable supporting. When they returned to see me after their babies had been born they shared their experiences, some were good, others less so.

The process of thinking and writing enabled me to give time to '*thinking*' about my study. In doing so I appreciate that I come to the research with existing opinions and beliefs that colour the research. The effect of these preconceptions is that, '*there is no escape at all from the fact that the research interaction is a genuine human encounter, and that nothing can be done to stop the behaviour of the researcher being meaningfully communicative*' (Ashworth, 1987, p. 18). As a homeopath I had the expectation that homeopathy was useful during pregnancy and childbirth, however I was undecided about whether homeopathy could be incorporated into another professional discipline. For instance, would midwives still be midwives if they practiced homeopathy; was homeopathy a modality used within any relevant profession or was it a professional discipline in its own right. As I started to read around the topic I came to the realisation that the issues were more varied and complex than I had initially determined, and my own views perhaps too simplistic and the lens rose tinted.

The next section shares some reflections on my reading with the reader. I hope this will enable the reader to understand the context in which the midwives in the study function. These issues will be revisited in greater depth in chapter two.

### **1.3 Framing the research: A crisis in healthcare**

There is currently a crisis in healthcare in the United Kingdom and beyond. This can be seen in the tensions that exist between the scientific-bureaucratic notions of guidelines and standards that are generated by managerialism and the Evidence Based Medicine (EBM) movement (Miles and Loughlin 2011) and the concerns of a lack of empathy and caring in the system, a finding subsequently confirmed by Francis (2013). These tensions are framed by an inherent risk-aversion in the system, and complicated by a consumerist ideology, that is presented as the choice agenda. This chapter will consider these key concepts and analyse how they have contributed to this crisis before examining the impact of this on midwives who have trained as homeopaths.

Aneurin Bevan, in responding to the Beveridge Report of 1942 (Beveridge 1942), aimed to develop a service that gave an opportunity for everyone to access quality healthcare, based on clinical need, free at the point of delivery (NHS 2014). In 1948, it was stated that the NHS had 480,000 hospital beds, 125,000 nurses and 5,000 consultants. Midwives were mostly employed and working on the district. However, even in its first year of operation the costs went from an estimated £148 million to £248 million (Tweddell, 2008). Bevan was reported as advising the House of Commons in 1948 that '*we shall never have all we need ...expectations will always exceed capacity*' (Allen 2007). This situation remains, and whilst the NHS of the 21st century is radically different to that of 1948, the costs are still rising. By

2010/11 the cost was reported as being £101.9bn (Gainsbury 2011), with the Institute of Fiscal Studies believing that this will need to increase substantially over the next decade to meet patient demand (Ramesh 2012). The NHS now employs 1.7 million people and deals with over one million patients every 36 hours (NHS 2014). The NHS receives its funding directly from the government, with the Secretary of State for Health holding ultimate responsibility for its operation. Other organisations with responsibility include The Department of Health, NHS England, clinical commissioning groups (CCGs), health and wellbeing boards, and Public Health England. The diagram, Fig 1 (p.25): Modernisation of health and care (DoH 2013) illustrates the current complexity of the NHS in the 21<sup>st</sup> century.



## The health & care system from April 2013

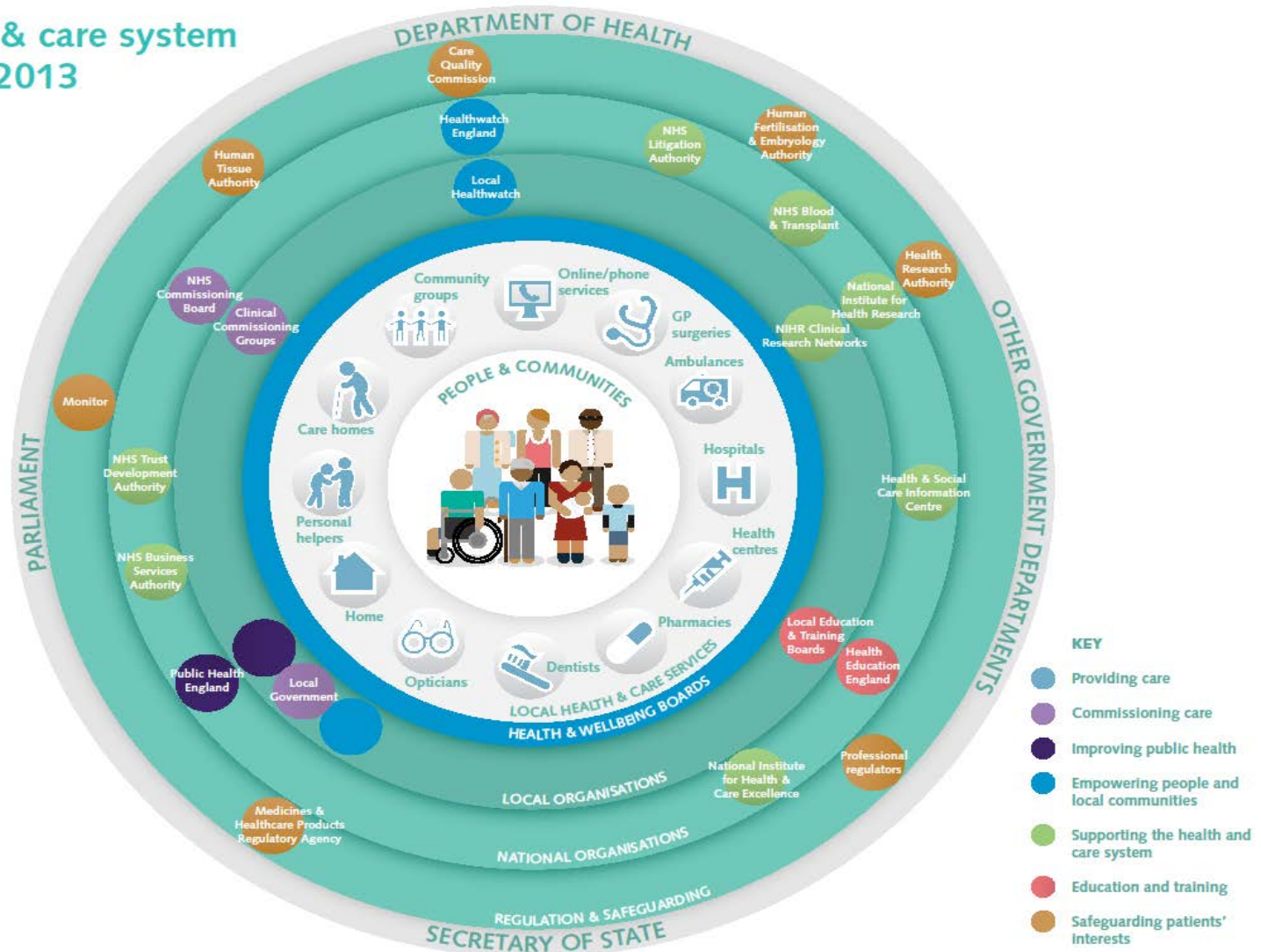


Figure 1: The health & care system from April 2013

An organisation as large and complex as the NHS requires careful management. However, constant reorganisation, and increasing complexity, coupled with greater bureaucracy, led to considerable criticism being levelled at it over recent years (O'Dowd 2011, Francis 2013). The long-awaited report by Francis (2013) into the failings of the Mid-Staffordshire NHS trust found what was described as a '*system wide failure*' leading to '*a lack of care, compassion, humanity and leadership*' at Stafford Hospital (Francis, 2013, p.1). As well as the call for compassionate care through the '6 C's' of care, compassion, competence, communication, courage and commitment there was a call for a structure that would support fundamental standards, openness, transparency and candour, which would be instituted across healthcare in the UK (Francis, 2013). As one of the responses to the recommendations made by Francis, Mike Farrar, a former chief executive of the NHS Confederation was requested to carry out a review into the levels of bureaucracy in the NHS (NHS Confederation, 2013). He noted that previous attempts to reduce the bureaucratic burden had failed, and made 30 recommendations to reduce this burden by a third. All the recommendations made by the review have subsequently been adopted. Nonetheless, Marsh (2014), a neurosurgeon, reported that he remained convinced about the rise of a '*new managerial class*' in the NHS to the detriment of staff and patients. Indeed, Francis (Smyth, 2014) believes that, even in 2014, health chiefs are still placing targets ahead of patient care, thus making it very difficult for hospitals to put patients first. This would suggest that some individuals consider that an ideology supporting bureaucracy remains strongly embedded in the NHS.

This bureaucracy also manifests itself in its support for evidence-based medicine. Eddy (2005, p.2613) notes how the term '*evidence-based medicine*' (EBM) has become part of a mantra that not only attempts to guide clinical practice, but is also

used to support research agendas, allocate financial resources and formulate healthcare policy (Lambert, Gordon and Bogdan-Lovis 2006). The EBM hierarchy that '*privileges randomised controlled trials (RCTs), scientific objectivity and statistically based truths*' only serves to promote a paradigm rooted in scientism (Jagtenberg, *et al* 2006, p.324). The use of a model of EBM embedded in scientism allows outcomes to be calculated in a way that had not been previously available. Therefore, rules and standards can be established. The use of set rules and standards means that those in possession of the '*right*' knowledge can determine the '*right course of action*'. Therefore, actions potentially become moral issues. People who choose not to follow the evidence are deemed as risking either their own or the health of others in a morally unacceptable way.

Paradoxically, as scientism has become increasingly dominant, so has the rhetoric about '*women centred care*'. The rights of women to make choices about the maternity care they receive has been an important element of government rhetoric over the past 15 years. Women centred care has been located within a political ideology based on free markets and the growth of consumerism (Pope, *et al* 2001).

As the NHS has become progressively target driven and bureaucratic to meet the rules and standards required, considerable censure has been levelled at it. Criticisms about the quality of care at North Staffordshire NHS Trust ultimately led to the Francis report (2013) that reported on the lack of compassion and empathy being shown to the users of the service. Rather than being a local or national issue, this concern about the quality of care is a worldwide problem (Scott, 2013).

It is the combination of my own interests and these concerns that led to the development of the research question.

#### **1.4 Research question**

The primary research question for this study comprises: What is the experience of midwives when they seek to become experts in two professional disciplines, one based within a NHS that operates on neoliberal principles: midwifery; and the other which tends to stand in opposition to this: homeopathy. Thus participants appear to straddle two paradigms, and I aim explore how they manage to do this, and assess the impact it has on them both personally and professionally.

#### **1.5 Structure of the thesis**

In this chapter I briefly introduced the reader to my research study. I described my motivations for undertaking the study as well as explained my aims and research question. Chapter two extends this and provides a more detailed background to the thesis. In it, I provide a history and context to the study, exploring the current crisis in healthcare, and examine the resulting tensions between risk, choice and the nature of evidence.

In chapter three I review the literature on the use of homeopathy/CAM in midwifery. This takes the form of a systematic review, and captures both clinical trials and surveys concerning the views and use of homeopathy by midwives and mothers.

In chapter four the theoretical perspective and methodology chosen for this study is presented. I provide a justification for approaching the study using a trio of different lenses.

Chapter five outlines the study design and methods used in the study. I explain the sampling process, ethical issues, data analysis and the trustworthiness of the data. I present my reasoning for choosing an interpretive hermeneutic approach for the study.

Chapters six through to eight present the interpretations from the study, using the three different lenses. In chapter six the data obtained from the participants are presented. The narratives are conceptualised through the metaphor of '*metamorphosis*'. This explains the midwives journeys as they develop into midwife homeopaths. In chapter seven data are framed using a Heideggerian lens. This lens is used to understand the midwives narratives as they transform into '*authentic*' practitioners. Chapter eight relates how this transformation into authentic practitioners affects the type and quality of the care they are able to offer women.

Chapter nine draws together the findings and discusses the limitations of the study before making recommendations for practice and research in this area. It is hoped that the findings from this study will enable a richer understanding about how authentic practitioners who are guided by a person centred approach can have a positive impact on the delivery of healthcare.

In chapter ten, I write about my own experiences whilst conducting this study.

## **Chapter Two: Background and key debates in the professions.**

### **2.1 Introduction**

The aim of this chapter is to conceptualise and analyse the key debates of choice, risk and evidence-based medicine within midwifery and homeopathy. In doing this, I want to briefly place each of the professions within its historical context, as without this historical appreciation it can be difficult to understand the reasons why each profession has emerged in their current form. Within this I consider the models of care that underpin midwifery before turning to a brief analysis of the complex interplay between risk and choice in midwifery, before exploring the impact of evidence-based medicine on the availability of homeopathy in the NHS.

### **2.2 Historical development of midwifery**

The history of midwifery has had a profound influence on the structure and philosophy of maternity services in the 21st century. Midwifery has not always had an easy relationship with medicine. It has also been shaped by various government policies. Historically, in common with many professions, the way midwives have been organised can be separated into two epochs, pre and post the creation of the NHS. The first part of this section discusses the development of the profession, from its earliest beginnings up to the launch of the NHS in 1948.

Prior to 1740 midwifery had been an almost entirely female domain. Female midwives, friends and neighbours attended to the majority of women (Wilson 1995). The church licensed female midwives as early as the 16th century under a 1512 Act of Parliament (Donnison 2004). Cody contends that the seventeenth century female

midwife held a privileged and powerful position at the interface between marital relations and the state, serving mothers and their communities. Female midwives held knowledge about female reproduction that was largely inaccessible to male knowledge and authority, as it was based outside the rational male domain of the time. (Cody 1999). Cody (1999, p.175) argues that, in the 17<sup>th</sup> century, because midwifery was based in '*a sympathetic attachment to fellow women*' and '*subjective feeling*' this both justified the exclusion of men from the public domain of midwifery and also prevented women being accepted within the public domains of the Royal Societies.

This practice continued until the 1740's when it became increasingly common for male doctors to attend childbirth. Attempts have been made to try and understand why this transition happened. Cody (1999) outlines some of the conventional explanations for this phenomenon. The first account details how the man-midwife was educated, gave lectures in midwifery, used forceps, fillets<sup>1</sup> and engaged in masculine ingenuity whilst maintaining his emotional detachment. Additionally, supporters such as John Nicols (1767, p.17) exalted the profession stating '*it is necessary to add that most excellent rule laid down by a wife man*'. Cody (1999) argues that this, in turn, led to '*sensible*' husbands seeking the services of men-midwives to attend to their wives.

However, from the mid-twentieth century a different historical interpretation was proffered, one that echoed the sentiments of Elizabeth Nihell, a midwife of the 1750's. This explanation described how male midwives and their supporters vilified their female counterparts, glorified their own achievements and used technology in

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<sup>1</sup> *Fillet: Nineteenth Century Obstetric Fillet with Horse Hair Loop. A turned wooden handle with a loop extending from top. The loop is made from horse hair which is lacquered, possibly with shellac. Used to drag the foetus into birthing position, usually to loop under the chin and other parts of the body. (St. Thomas Hospital)*



a way that was harmful to mothers and their babies. Cody (1999) argues, however, that neither account of '*medical glory versus gory misogyny*' (Cody 1999, p.477) adequately explains the transition from female to male midwives. In contrast, Porter (1998) offers another explanation, by suggesting that the rise in popularity resulted from the man-midwife '*cultivating*' his patients by being obliging and listening to their fears and concerns. The male midwife obtained his living by personal recommendation, not coercion, and this suggests they were meeting a ready demand for their services (Wilson 1995). Wilson attests that the social fabric of society was changing in this era, and with it women's culture. Upper-class women were becoming increasingly literate and instead of sharing tasks with their domestic help, started to delegate these to their servants. This, he argued, broke an important link between where women no longer shared their experiences across social divides.

According to Cody (1999) the eighteenth century male midwife presented himself as a person demonstrating both feeling and reason. He was both a man of the home as well as of the world. Midwifery and childbirth crossed the home/public divide and the rise of the male midwife demonstrated how the men and women of the period navigated between the worlds of the intimate and public. As a consequence, female midwives lost control over reproduction despite being well placed to offer their services to an ever-expanding population. One of the reasons put forward for this is that as discussions about reproduction became '*interesting*' and the knowledge and understanding about reproduction grew, so did its inclusion in '*rational-critical*' circles. Male midwives placed themselves as making a useful contribution towards helping the burgeoning population and hence the country's economy. A spokesperson for a number of London hospitals at the time is reported as stating that their hospitals (Nicols 1767, p.33):

*Secure the birth, and protect the tender life of infants, who may hereafter be usefully employed in trade and manufacture, or supply the waste of war in our fleets and armies.*

This increasing popularity of the male midwife contributed to the decline of midwifery practised by female midwives (Donnison 2004). Their special position as midwives had been eroded and in London, licensing was removed by the 1720's. Over time the use of the male midwife cascaded down the social classes and became popular in provincial cities as well as London (Lowis and McCaffery 1999). With the upper and middle class using men midwives, female midwives were left tending to the less well off in society, and this affected both their status and income. These are identified as some of the reasons for their lack of group organisation and political influence. At the same time other healthcare professions were organising themselves, establishing standards for education and registration (Lowis and McCaffery 1999). The authors assert that there was also a reluctance to organise the training and registration of midwives based upon a societal belief in a free market and minimum levels of government intervention.

From 1840 onward concerns were raised about the high levels of maternal mortality and discussions took place about how this situation could best be addressed. A number of male practitioners took the opportunity to call for the abolition of female midwives, whilst others wanted the occupation to come under medical control. To counter this, and improve the status of midwives, a London midwife, Zepherina Veitch, and Louisa Hubbard, the editor of a woman's journal called *Work and Leisure* established the Trained Midwives' Registration Society in 1881, later changed to the Midwives Institute in 1886. The aims of the organisation were to improve the statutory position of midwives, and promote education and training for midwives. In 1902 the first Midwives Act for England and Wales reached the statute

books, and the Central Midwives Board created to maintain a register. The Act both protected the title of *midwife* after 1910 and allowed the Central Midwives Board to maintain standards within the profession and remove midwives from the roll. The Midwives Act 1902 subsequently amended by later Acts in 1918, 1926 and 1936, became incorporated into the National Health Service Act of 1946.

Once included in the NHS, midwifery continued to evolve in line with a number of reports, including the Cranbrook Report (1959), the Peel Report (1970), the Maternity Care in Action Report (1982), Changing Childbirth (DH 1993), Maternity Matters (DoH 2007) and Midwifery 2020 (2010). The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) was established in 1983. Its role was to register and maintain professional standards. In addition the government established National Boards for each of the constituent UK countries to both monitor educational standards and keep training records for nursing and midwifery courses. In 2002 the Nursing and Midwifery Council (NMC 2002) assumed the collective responsibilities of both the UKCC and the English National Board, with other countries choosing to establish new bodies in lieu of their National Boards (NMC 2013). The stated aim of the NMC is to act as a regulator for the nursing and midwifery professions in order to '*safeguard the health and wellbeing of the public*' (NMC 2014). The changes that have contributed to the structure of today's maternity services are explored in the following section.

Since the inception of the NHS the government has been responsible for the publication of a number of pivotal reports that have helped to shape maternity services. Initially, these reports promoted hospital over home births (Campbell and Macfarlane 1987, 1994). The first of these was the Report of the Maternity Services Committee (Ministry of Health, 1959). The government commissioned the

report as a response to the Guillebaud inquiry (Ministry of Health and Scottish Home and Health Department 1956) set up to examine the cost of the NHS. It reported that maternity services were in disarray and recommended a comprehensive investigation. The government appointed The Earl of Cranbrook to chair this investigation. During their inquiry the committee sought the views of a number of organisations including the Royal College of Obstetricians and Gynaecologists (RCOG), the College of General Practitioners, the Medical Practitioners Union, the Catholic Women's League, the National Birthday Trust, the British Dental Association, the Royal College of Midwives (RCM) and the Association of Supervisors of Midwives. Regional Health Boards, the RCOG and various women's organisations gave evidence about the place of birth. What is significant in this debate is that the RCOG stated '*that in their opinion hospital confinement offered maximum safety for the mother and the baby*' (Ministry of Health 1959, p.17), a view not shared by General Practitioners. It was reported that hospitals were not able to meet the demand for hospital confinements.

Concerns were also raised about the potential for infections to be passed to mothers and their babies, and the belief that hospitals were for people who were ill, not to meet the preferences of women who could quite readily give birth at home. The physical and psychological advantages of home births were also debated and centred around breast feeding, bonding between mothers and their babies, lower infection risk and less disruption to the mother, baby and family. Notwithstanding these opinions, greater weight was given to the testimony provided by the RCOG stating that hospitals were the safest place to give birth (Ministry of Health, 1959). These views informed the report which recommended that 70% of all confinements should occur in hospital.

Less than ten years later, the policy towards giving birth in hospital was further strengthened by the Peel Report (1970). This was commissioned to review the future of the domiciliary midwifery service and to make recommendations about the provision of maternity beds (Madi 2001). Sir John Peel was, at the time of the Peel Report president of the RCOG. The Peel Report (1970, p.60) when published stated:

*We consider that the resources of modern medicine should be available to all mothers and babies, and we think that sufficient facilities should be provided to allow for 100 percent hospital delivery. The greater safety of hospital confinement for mother and child justifies this objective.*

Not only did they recommend hospital care, they also recommended that, instead of working alone, midwives worked as a team alongside consultants and general practitioners. The report has been heavily criticised for its stance on hospital birth. The report pays scant attention to the views of the Chairmen of Local Medical Committees who were in favour of continuing providing home births. Other opponents considered that decisions were made without sufficient evidence (Madi 2001).

A further ten years elapsed before the Short Report (1980) examined perinatal and neonatal mortality in maternity care. This report was commissioned as a response to concerns that too many babies were suffering permanent disability or dying during late pregnancy or early infancy (House of Commons Social Services Committee 1980). One of the areas examined by the committee concerned the best place to give birth. Mothers supported the notion of giving birth either at home or in GP units; however, the RCOG disagreed arguing that GP units were not safe

places to give birth. In reaching their conclusions the committee stated that whilst women had expressed a clear preference about where they would like to give birth this had to be balanced with the requirement to reduce perinatal and neonatal mortality. Tew (1998), and Sandall (1997) wrote that consultant advisors were protecting policies already agreed within their own profession, rather than attending to the task of producing factual evidence. When the committee presented their report the recommendations included not only support for all births to take place in hospital, but also the preference that births should take place in consultant units. It was believed that these better equipped and staffed units would improve birth outcomes. The committee also recommended that home births be limited further. This was in spite of the existence of studies that questioned the evidence for the effectiveness of obstetric hospitals in reducing mortality rates. (Sinclair, Torrance, Boyle *et al* 1981, Royal College of Physicians of London 1988). Whilst the previous inquiries noted the expertise of midwives, the Short Report was pivotal in moving towards a more interventionist approach and the increased medicalisation of birth. This in turn adversely impacted on the role of the midwife in the maternity team. Not all supported the recommendations and groups of women and women's organisations actively protested against the changes (Herron 2009).

It was only during the 1990's when the Department of Health (1993, p.25) published recommendations that:

*Women should receive clear, unbiased advice and be able to choose where they would like their baby to be born. Their right to make a choice should be respected and every practical effort made to achieve the outcome that the woman believes is best for her baby and herself.*

This represented a shift away from a paternalistic approach suggesting that professionals know best, to a consumer-based approach to childbirth. In the past the Department of Health had largely ignored the views of women and women's organisations. Madi (2001) suggests this change of view to be a result of the Winterton (House of Commons Health Committee 1992) and Cumberlege (Department of Health 1993, 1993b) reports. The Winterton report had been commissioned as the government after they recognised that the maternity services of the time were unable to meet the needs of the women they served. The Winterton Report (1992, p.1) acknowledged that the experience of giving birth was important to women and their families stating:

*We set out on this inquiry with the belief that it is possible for the outcome of a pregnancy to be a healthy mother with a healthy, normal baby and yet for there to have been other things unsatisfactory in the delivery of the maternity care. Women want a life-enhancing start to their family life, laying the groundwork for caring and confident parenthood...*

The committee took evidence from a number of stakeholders and determined that the evidence did not suggest that hospital birth was the safest place for all women. The report stated (Winterton Report 1992, p.xii):

*On the basis of what we have heard, this committee must draw the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety.*

Whilst the Winterton Report drew the future shape of maternity services, the Changing Childbirth Report (Department of Health, 1993) explored the views of women via the Market and Opinion Research Institute (MORI). Women responded by saying how they felt they had been presented with very little or no choice about the place of birth. However, it also reported that women's views as consumers of health care were beginning to be given more credence (Van Teijlingen, *et al* 2004).

Included amongst the report's recommendations were that women should have a named midwife, to enable them to have continuity of care and encourage them to make informed choices. Furthermore, the report also reinforced the need for midwives to be enabled to act autonomously.

This was strengthened by the Maternity Working Care Party publication, Modernising Maternity Care, a joint publication by the RCOG, Royal College of Midwives (RCM) and the National Childbirth Trust (NCT) (2001) that recommended that all women should be '*booked in*' by a midwife, and experience one to one care in labour. The report led to the establishment of benchmarks for the provision of a quality maternity service (Kitsinger 2003). The past decade has seen a shift towards the promotion of birth at home or in midwife led units, as there is evidence to suggest that this delivers better outcomes for women with low risk pregnancies (World Health Organisation (WHO) 1996; Birthplace in England Collaborative Group 2011; National Institute for Health and Clinical Excellence (NICE) 2007). Indeed, there has been a reduction in the number of obstetric units in the United Kingdom and an increase in midwifery led units since 2007 (Redshaw, Rowe, Schroeder *et al*, 2011). Despite this, the number of births taking place at home still remains very low at 2.5% (Redshaw, *et al*, 2011), and the number of women experiencing a spontaneous delivery is at an all time low of 60.9%, according to Birth Choice UK (2013).

The most recent report entitled '*Midwifery 2020, Delivering Expectations for the Future*' (DH, 2010) examined the role of the midwife and scoped midwifery and maternity practice in the United Kingdom. This culminated in the development of a '*vision*' (DH, 2010, pg 45) of midwifery for 2020, and included the contribution of



midwives; mothers, fathers, partners, families and consumer groups; the maternity care team; commissioners of maternity services; service providers; educationalists; researchers, and government leads, regulatory bodies and professional bodies.

These changes, when taken together, represent significant shifts in the policies that underpin the care provided to mothers in the NHS.

What is evident, however, is how difficult changing behaviour can be, whether that is the institution, the midwife, or mothers. Changing behaviour is a complex topic, and one that lies outside the scope of this thesis; however Deery (2004, p.162) notes how midwifery culture had remained unaffected for a long period, in spite of its continuously changing framework. Maternity staff were, they state, very resistant to change. They posit a number of reasons for this resistance. These included an absence of trust or confidence in managers, displeasure about the way changes were managed or a lack of involvement of the people affected by the change. Deery discusses how, it is only recently that researchers have challenged some of the '*entrenched cultural codes and routinised practices*' in the NHS. The midwives need for consistent management and support were not being recognised and this, in turn, led to a resistance to change.

Having explored the policies leading to change, this section will begin by discussing the characteristics of some midwives in the 20<sup>th</sup> and 21<sup>st</sup> centuries. Like other professional groups, midwives adopt styles of practice and this aligns them with different philosophies of care. The impact of this on the way maternity care is offered to women will also be explored.

### **2.3 Characteristics of late 20<sup>th</sup> and early 21<sup>st</sup> century UK midwives.**

In 2008 the number of working midwives was put at thirty five thousand, three hundred and one (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales 2010). Most midwives were female (35,169), of whom 57% worked part time. One hundred and thirty-two male midwives (3.77%) were registered with the NMC (2013). Ninety-six percent of midwives work in the National Health Service (NHS). In 2008 the average age of a midwife was 42 years. Two-thirds of midwives were aged over 40 and a quarter over the age of 50. It was estimated that 40-45% of the midwives in the 2008 survey would reach retirement age by 2018.

The number of nurses and midwives undergoing initial registration is decreasing and the number of nurses and midwives choosing to leave the register is increasing on a yearly basis (NMC 2013). The latest available figures show that in 2008 the number of initial registrations was 25,364 with 36,203 nurses and midwives choosing to leave their respective profession. It is already recognised that there is a shortfall in the number of practising midwives, and the situation will only worsen as the majority reach their retirement age of 55 (Warwick 2013).

In 2007, and repeated in 2011 Redshaw, *et al*, conducted a study where they mapped maternity care in England. The aim was to examine the configuration, location and providers of maternity care. The emergent picture was of a complex and changing provision. The researchers discovered that whilst two thirds of Trusts had one or more obstetric units in 2007, by 2010 this had reduced to 49%. At the same time the number of Trusts with alongside maternity units (AMU's) had increased by 15% to 35%, and the number of Trusts with freestanding maternity

units (FMU's) had increased from 18% to 24%. The overall number of maternity units had increased by 11% during this period. FMU's were more frequently found in the southwest whilst AMU's were more frequently found in the London and south-central strategic health areas. Intrapartum care was mainly to be found in obstetric units. Obstetric units were found to be providing care for more than 95% of women giving birth in hospitals (1% in FMU's and 3% in AMU's). Homebirths, including planned and unplanned, accounted for only 2.5% of births<sup>2</sup>. Twelve percent of maternity units reported GP involvement in intrapartum care, largely through FMU's (n=2) and OU's (n=30). FMU's and AMU's were more likely to offer early labour assessment at home with a midwife, although nearly all units offered a telephone for labour triage service. Seventy-nine percent of units had a fixed birthing pool. Obstetric units, as one would expect were more likely to offer specialist medical services including 24 hour epidurals, dedicated obstetric theatres, adult and neonatal intensive care units and obstetric high dependency beds.

At the time of the survey there was a total of 19,415 full-time equivalent midwifery posts in existence and 5,263 full-time equivalent maternity support worker posts. There were also 3,864 whole time equivalent medical staff working in obstetrics, almost all of who worked within the obstetric units. The staffing levels varied and per 1000 births were higher in FMU's (35 per 1000 births) than in AMU's and OU's (31 per 1000 births). The number of maternity support staff was also higher in FMU's (23 per 1000 women) in contrast with AMU's and OU's (0.7 per 1000, and 0.8 per 1000 women respectively). Between 2007 and 2010, maternity services have been increasing, with over 77% increasing their midwifery establishments, 80% increasing the number of obstetricians and 77% increasing their paediatric

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<sup>2</sup> Figures exceed 100percent as they are rounded up.

cover. The report identifies that changes to specialist medical training have impacted on the way that maternity care is being organised especially in OU's and AMU's.

Whilst the statistical data provide useful information, there is little detail about how decisions are made about the type of maternity care being offered, or how women are guided through making maternity choices. This will be addressed by exploring the philosophies underpinning maternity care, and the currently culturally normative concept of the role of the midwife.

## **2.4 The role of the midwife**

The International Confederation of Midwives (ICM) is an accredited non-governmental organization set up to represent, support and strengthen professional midwifery associations. The ICM (2011) describe a midwife as:

*A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.*

*The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the new-born and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.*

*The midwife has an important task in health counselling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.*

*A midwife may practise in any setting including the home, community, hospitals, clinics or health units*

(International Confederation of Midwives, 2005)

This definition is useful in articulating the aspirations and potential scope of midwifery practice globally. It describes a midwife as an accountable professional, taking full responsibility for the management of normal birth. It also shows the extended role of the midwife in health counselling, education, sexual and reproductive health and childcare. However the philosophies underpinning the statements are implicit, and there is no reference to the tension that exists between the technocratic and social perspectives that inform maternity services (van Teijlingen 2005). The next section briefly explores the philosophies underpinning maternity care before considering the impact of these on the care offered to mothers.

## **2.5 Philosophies of maternity care in the 20<sup>th</sup> and 21<sup>st</sup> centuries**

The post war years were a time of increased public confidence in medical science and hospitals represented the '*bright new world*' (Scott-Samuel, *et al* 2012). This led to an increase in the public demand for hospital births, under the overall care of obstetricians. This transition to hospital care as the norm, instead of reducing risk, has been associated with a corresponding increase in medical intervention (Walsh and Downe 2004). The situation started to change again in the 1970's when professional and lay interest in '*natural childbirth*' started to expand. In response to

this, the government published a number of position documents (Department of Health 2007; Welsh Assembly Government 2005; Scottish Executive 2001). This position was further strengthened in England through the Prime Minister's Commission Report on the Future of Nursing and Midwifery in England (2010).

Whilst both obstetricians and midwives share the goal of achieving a safe birth for mother and baby, the philosophy of care in different places of birth can be fundamentally very different. Generally, in the larger obstetric led maternity units, the needs of the institution tend to take precedence over the needs of the women or midwives, and there has been an adoption of a medical or technocratic approach (Hunter 2005). By contrast, midwife led, out of hospital units lean towards using the social model which places the needs of women more centrally (Chief Nursing Officers 2010). The debate surrounding the different models has been extensive. The adoption of one or other of the models creates the environment in which births take place, and has the potential to hugely influence the type of birth experience a woman has and the degree of intervention that takes place.

### **2.5.1 Technocratic philosophy of childbirth**

First described by Davis-Floyd (1994), the technocratic philosophy views birth objectively. The pursuit is the safe delivery of a baby. The use of technology is a central feature of the approach, as is the use of a particular type of scientific evidence (EBM)<sup>3</sup> to underpin optimal care. This model owes its philosophical origins to 18th century scientists including Descartes, Bacon and Newton (Downe

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<sup>3</sup> Evidence-based medicine (EBM) is 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)  
Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS (January 1996). 'Evidence based medicine: what it is and what it isn't'. *BMJ* 312 (7023): 71–2. doi:10.1136/bmj.312.7023

and McCourt 2008). The female body is likened to a machine, an analogy reflecting the technical and industrial developments of the period. This idea of the female body as machine remains today in many areas of health care practice, whereby the hospital can be likened to a factory actively managing birth on a conveyor belt or production line within standard times and using standard processes (Kitsinger 1999, Walsh 2006).

### **2.5.2 Social philosophy of childbirth**

The social philosophy of childbirth, in contrast, is more closely aligned with the ICM definition of the role of the midwife (section 2.4), and offers a holistic approach recognising birth as a normal physiological process that is nurturing of both mother and baby. Walsh (2006) noted how the social philosophy promotes midwives '*being*' rather than the '*doing*' that is evident within consultant led hospital units. This '*being*' captures the essence of '*being with woman*'. The social philosophy of care encompassing '*being with woman*' includes the giving of emotional, physical, spiritual and psychological presence and support (Hunter 2002). Edwards and Byrom (2007, p.15) consider the social philosophy as '*woman-centred care [that] encapsulates terms such as trust, respect, empowerment, facilitation and working in partnership with the woman and her family to maximise health outcomes.... The social model acknowledges childbearing as part of the fabric of people's lives*'. Increasingly there is a call for the recognition and inclusion of the social philosophy of care in midwifery services. This is evident in the 2014 Lancet series of articles on midwifery. The first of these by Renfrew et al (2014: p.1129) examined '*the contribution midwifery can make to the quality of care of women and infants globally, and the role of midwives and others in providing midwifery care*'. In doing so they developed a framework of care that included caring, respectful, empathetic and kind staff who generated trust in their relationships with women. This care

was provided in a setting that both valued and promoted the needs of individual women and normal reproductive processes.

A comparison between the social and technocratic philosophies can be seen in

Table 1.

<b>Social philosophy of childbirth</b> <i>'normal till proven otherwise'.</i>	<b>Technocratic philosophy of childbirth</b> <i>'abnormal till proven otherwise'</i>
<p><b>Physiological/natural</b> – pregnancy and birth as ‘normal’ natural life event;  <b>Art</b> – intuitive, holistic  <b>Social</b> – family and community orientated; health and social care should not be considered separately.  <b>Holistic approach</b> – acknowledgment of link between social structures and health care to attain state of well-being.</p>	<p><b>Scientific</b> – pregnancy and birth can only be normal after the event when nothing has gone wrong.  <b>Medical</b> – aims to reduce maternal and infant mortality; to cure rather than prevent  <b>Medically-led</b> – professional in charge of pregnancy  <b>Control</b> – birth in hospital enabled medical staff to be in control of the birth  <b>Interventionist</b> – doing things to ‘help’ women</p>
<p><b>Qualitative</b> – importance of a ‘good’ experience for women and their family.  <b>Subjective</b>  <b>Spiritual</b> – part of wider culture  <b>Intuitive</b> – rely on experience, relationships and instinct as to what is right or wrong  <b>Environment</b> – central to model  <b>Local community focus/environment</b> – central to model; women give birth at home or in local community, supported by friends and family; her choice.  <b>Feminine</b> – women-centred respect and empower; women feels in control  <b>Outcome</b> – aims at live healthy mother, baby and satisfaction of mother/family</p>	<p><b>Quantitative</b> – task orientated; ‘checking – such as observations’  <b>Objective</b>  <b>Treat the problem</b> – treatment of the disease (pregnancy) rather than care of the whole; anticipate problems  <b>Environment</b> – peripheral to model  <b>Centralised hospital maternity services</b> – birth in hospital seen as the safe option    <b>Masculine</b> – paternalistic, empowerment of the medical profession  <b>Outcome</b> – aims at live healthy mother and baby</p>

Table 1: Comparison between the technocratic and social philosophies of childbirth (adapted from MacKenzie Bryers and van Teijllingen 2010:491)

The features underpinning the social philosophy of midwifery are similar to those discussed in section 2.7.1 that support the practice of homeopathy. These elements support the notion of both midwifery and homeopathy as incorporating the ‘art’ as well as ‘science’ of practice (Kent 2003, Melo 2013, Wolfenberg 2015).



The next section considers a range of factors that impact on the provision of maternity care and help determine which philosophy underpins the care available to women.

## **2.6 Influences on maternity care in the United Kingdom**

As briefly discussed in chapter one, maternity care in the United Kingdom can be better understood if the political and social context in which it is offered is analysed. The underpinning ideology of neoliberalism has made a significant contribution to a number of tensions surrounding the provision of maternity care in the UK. In this section I consider the notions of '*choice*' and '*risk*' in maternity care. These are in turn affected by current interpretations of evidence-based medicine.

Originally, set up and operated within a welfare state, the NHS provided free care, at the point of delivery to patients. Services within the NHS were '*decommodified*' and there were no internal markets (Davidovitch and Filc 2006, p.299). However, over the past 30 years, a neoliberal ideology has developed as the foremost political, philosophical and economic doctrine in the UK (Harvey 2007, Peedell 2009). This ideology, in a range of incarnations, underpinned the Thatcher, Major, Blair, Brown governments, and remains the dominant force in the Cameron and Clegg coalition. According to Turner (2011) neoliberalism is based upon a number of central principles. Those relevant to health care and hence midwives include an increased reliance on free markets with minimal government intervention; a high value placed on entrepreneurship, personal responsibility and self-reliance; and the rejection of collectivism.

The implementation of these principles contributed to the increased privatisation of public services; the use of private finance initiatives and public private partnerships; the introduction of private sector management practices to the public sector and the use of the voluntary sector to provide public services. An examination of the time line detailing the encroachment of neoliberalism in the NHS reveals that Margaret Thatcher initiated the process with the implementation of internal marketisation. Simultaneously, her government (1979-97) commissioned a report, headed up by Roy Griffiths deputy chair and managing director of Sainsbury's (Griffiths Report (1983) which recommended the introduction of general managers into the NHS. New Labour whilst opposed to many of the previous government's policies, continued with Private Finance Initiatives (PFI's). This allowed public service investment whilst still keeping to the Treasury's rules on spending. However, NHS spending was not keeping up with the demand for its services. The government, determined to invest heavily in the NHS, wanted NHS reforms to take place in return. Amongst the reforms patients and service users were placed as consumers of services. In 2010 the coalition government extended these reforms, increasing privatisation and marketisation in the NHS.

Managers in the form of '*new public management*' (NPM) were a vital element of the reforms. There was an increase in managerialism and bureaucracy (Scott-Samuel, *et al* 2014, p.61). Hood (1991, pp.4-5) stated that NPM included the use of '*explicit standards and measures of performance*', an '*emphasis on output controls*' and the promotion of '*economy in resource allocation*'. The effect of the emphasis on measurement led to a '*culture of audit*' (Iles 2011, p.19). According to Iles, this practice reduced creativity and innovation. Once healthcare is subject to measurement any potential for risk can be quantified. Risk becomes inherent and helps to determine choice. It was during this period that EBM found a home.

According to Hart (1997) EBM was an important element that allowed state run medical services to be run in the same way as manufacturing industry.

This prevailing culture is accompanied on the one hand by a message that childbirth is an inherently risky process which requires medical management, yet on the other that choice is a consumer right. This section analyses the tension created by these competing notions.

### **2.6.1 Risk**

According to Beck (1992), a sociologist, society has passed through '*pre-industrial society*' and the '*industrial society*' and has now entered the '*risk society*' era. Beck explains that entering this '*risk society*' was not by choice. Risk is a product of advanced industrialisation whereby the system produces risks that '*undermine and/or cancel the established safety systems of the provident state's existing risk calculation*' (Beck 1996, p.31). To illustrate this Beck provides examples of genetic engineering and nuclear power. Beck argues that contemporary risks cannot be '*safeguarded, compensated or insured against*'. He states that '*Industrial society has involuntarily mutated into risk society through its own systematically produced hazards, balances beyond the insurance limit*' (Beck 1996, p.28). Thus '*risk*' permeates every activity of modern day living, despite the fact that as far as health is concerned, morbidity and mortality rates have reduced.

Downe (2008), in applying this to maternity care suggests that a number of factors contribute to our conceptual appreciation and understanding of the notion of risk. The dominant discourse is of birth being associated with risk. Women are subject to

a constant bombardment of information, which sensitises them, and indeed society more generally, to the idea, that pregnancy and childbirth is inherently risky.

Whilst pregnancy and childbirth have always been considered risky events, the risk of maternal death has been greatly reduced from one percent in Elizabethan times to around one hundredth of this figure between 1983 and 2008 (Bewley and Helleur 2012). Notwithstanding this, Downe (2008) highlights that, as a 21<sup>st</sup> century consumer society, there are high expectations of care, combined with a low acceptance of risk. The public requires accountability from their institutions and professionals, and a failure to meet those expectations can result in litigation. Alongside the rising expectations of health outcomes, there has been a corresponding rise in the expectation that treatments are evidence-based, and as a consequence much of the research contributing to evidence based medicine is quantitative, focusing on attempts to obtain proof through objective measurement (Hesketh and Laidlaw 2002). McLaughlin (2001) states that the notion of risk becomes seen in clinical terms, and the management of risk becomes a scientific matter (McLaughlin 2001). Consequently, risk becomes connected to adverse outcomes or negative events for women. Permezel (1987) argues that by imposing a risk category onto women, they are being subjected to a type of micro-social regulation, which effectively brings about acquiescence. Women are constantly subjected to the language of risk, and are divided into low-risk and high-risk categories. This labelling of risk ensures that all women are made aware of '*risk*' which is in itself can be harmful to women. The term is a negative one with negative consequences, and there is never a '*no risk*' situation in pregnancy and childbirth (Lupton 1999). Even those women who are at low risk become the object of medical surveillance and intervention. Women are also '*expected to exercise self-surveillance*' over their own body, and if they fail to do so they are deemed

irresponsible (Lupton 1999, p.66). To be a responsible mother is to attend to risk and to minimise it by acceding to the prevailing medical model (Possamai-Inesedy 2006). Women are understandably '*risk averse*' and will choose the place and type of birth that they feel and are led to believe will minimise any risk to themselves and particularly their babies.

Where the technocratic philosophy is the dominant philosophy then both wards and staff expect to be in constant readiness for something '*bad*' to happen that requires clinical management. In assessing risk and providing justification for the medical model, obstetricians such as Permezel, *et al* (1987) examine the level of intervention received by women giving birth in hospitals or who need to be transferred to hospital. They state that even low risk women are '*at risk*' and that whether someone will need intervention cannot be known before delivery, therefore, every woman should be delivered of their baby in a hospital where technology is available. Permezel, *et al* (1987, p.22) state that '*despite careful selection of a low-risk population there remains a persistent incidence of potential serious complications and a continuing need for obstetric intervention*'. If this premise is accepted, birth is risky and unexpected consequences occur. The logical conclusion of this belief is that hospitals are needed for all birthing mothers. Brody and Thomson (1981, p.997) call this the "*maximim strategy, whereby the best is made of the worst possible outcome, regardless of the actual probability of that outcome occurring*". They go on to argue that, contrary to reducing risk, this approach tends to underestimate the risks of an intervention and to overestimate the usefulness of the maximim strategy.

In contrast, there has also been a sustained message about '*choice*' from

consecutive governments. Policies state that midwives must support women's decisions about their maternity care and in particular they must encourage normal birth wherever feasible. These tensions are apparent in the polarized debate between the social or midwifery model and the medical model of childbirth as defined in section 2.5, and can be perceived in an examination of choice in maternity care.

### **2.6.2 Choice**

Choice is one of the most commonly debated aspects of childbirth. Choosing the type of maternity care, place and manner of childbirth, appear as central elements of maternity policy in the United Kingdom (Jomeen 2006). However this same choice has also been described as largely illusory (House of Commons 2003). This section will examine the meaning of choice from the perspectives of the government, midwives and women.

It has been noted that women's choices are also greatly influenced by the views of their midwife or doctor (Jomeen 2006, Jomeen 2007, Lothian 2008). Jomeen (2006) found examples where women reported their General Practitioners (GP's) as stating that if they chose to have a home birth then they would have to choose a different doctor. This behaviour is also believed to exist in hospitals with midwives providing or withholding information according to the rules of the hospital, trust or obstetricians (Lothian 2008). Levy (1999) found that midwives '*gently steer*', '*coax*' or even use subtle blackmail on women, persuading them into making choices that sit comfortably with their own views and convictions. Weaver's research (2000) discovered that some midwives induced fear in the mother by stressing the dangers of home birth. Others (Green, et al 1998, De Vries, et al 2001; Kirkham 2004) put

their case more strongly, with Lothian (2008, p.36) stating that '*women are coerced, steered, or manipulated*' into making choices that sit well with others. Edwards (2005), when interviewing a group of Scottish women aiming to have a homebirth, found women telling stories about how they struggled to maintain their autonomy during this period. The Association of Improvements in the Maternity Services (AIMS 2013) concurs, and described stories of women being bullied into attending hospital for birth. On the other hand, when women are provided with positive stories about the experience of homebirth and supported by midwives, there is a rise in the rate of homebirths (Edwards 2005).

It is reported that whilst up to 80 percent of women are happy with their maternity care they would have preferred more choice about the type of care received and the place of birth (DoH 2005). Snowden, *et al* (2011, p.1) state that whilst women '*appear to desire choice*' their choices are determined by their perception of risk, their existing belief system and the resources made available to them. Despite the findings of the DoH, Snowden, *et al* (2011) and Kightley (2007) report that women still believe that hospital is the safest place to give birth. These findings appear to fit with the observation that, whilst there would appear to be support for normal birth amongst academics and the RCM, this is not always reflected in the clinical area. Jowitt (2011) believes that the pro-hospital message delivered over the past 40 years needs to be altered before any change could happen. Obstetricians and midwives need to inform women that other places are just as safe as hospital for having their babies, and that they are not being asked to accept a lesser standard of care.

So far in this chapter I have considered the historical development of midwifery, a midwife's role, and examined a variety of key influences on maternity care in the United Kingdom. I now turn to a similar consideration of homeopaths and homeopathy. In particular, I explore its underpinning philosophy, together with an evaluation of the impact of the currently accepted definitions of Evidence Based Medicine on its practise. An understanding of each profession is a necessary precursor to an analysis of the impact that becoming a homeopath has on a midwife's practice.

## **2.7 Introduction to homeopathy**

In the previous section I described the historical development of midwifery and how this had created the tensions between concepts of risk and the availability of choice for women. I now turn to an examination of homeopathy detailing why and how the debates surrounding its perceived '*lack of evidence*' have developed. I then draw the various strands together to illustrate how the debates on risk, choice and the nature of evidence play out.

Homeopathy was developed by Samuel Hahnemann (1755-1843) and is based on '*similia similibus curentur*', similitude or '*like cures like*'. The law of similars (or similitude, as it is also known) purports that any substance that can produce symptoms in a healthy person can cure those same symptoms in someone who is sick. The principle pre-dates Hahnemann, and is referred to by Aristotle (Janko 1987, p.187), Paracelsus (1493-1541) and Hippocrates (460-370BC), who stated that '*by similar things a disease is produced and through the application of the like is cured*' (Classic Homeopathy 2013). During his lifetime, Hahnemann published 6 editions of his text '*The Organon of Medicine*'. The first of these was published in



1810 with the final sixth edition appearing in 1921, almost 80 years after his death in 1843 (Fisher 2012).

### 2.7.1 Philosophy underpinning homeopathy

Homeopathy is located within the tradition of ‘*vitalist*’ medicine. Hahnemann believed that disease was a derangement of this ‘*vital force*’. He considered that the maintenance of health was a result of struggle against pathogenetic influences against which the body has to defend itself. These influences include not only environmental, physical and emotional influences, but also transmitted disease. Given that germ theory only became fully accepted in the mid to late 19<sup>th</sup> century (Cohn 2013), Hahnemann did not have the language to describe these at the time. Instead he used terms such as ‘*miasm*’ and ‘*contagion*’. Hahnemann, like many others of his time also believed in moral and intellectual growth and saw the potential in health to achieve this:

*‘In the healthy human state, the spirit-like force...that enlivens the material organism (the body)...governs without restriction and keeps all parts of the organism in admirable, harmonious, vital operation, as regards both feels and functions, so that our indwelling rational spirit can freely avail itself of this living, health instrument for the higher purposes of our existence.’*

(Hahnemann 1810, Aphorism 9)

*‘The material organism thought of without life force, is capable of no sensibility, no activity, no self-preservation. It derives all sensibility and produces its life functions solely by means of the immaterial vesse[n] (the life force), that enlivens the material organism in health and in disease’*

(Hahnemann 1810, Aphorism 10)

Those adopting a '*vitalist*' approach to treatment do not seek to target symptoms directly, but instead attempt to treat '*the whole person*' by observing and understanding the person '*in illness*' and re-establishing a health state of being.

## **2.8 A brief history of homeopathy**

Homeopathy quickly became popular and was used extensively during the 19<sup>th</sup> and early 20<sup>th</sup> centuries before experiencing a decline. A variety of reasons have been proffered for this decline, ranging from the conflict between homeopaths and members of the American Medical Association to the introduction of new, effective, drugs and treatments (Brown, 1979). A brief resurgence in homeopathy was noted in the latter part of the 20<sup>th</sup> and early part of the 21<sup>st</sup> century, however the number of practising homeopaths has been falling once again (Duckworth, et al 2011).

An orthodox physician, Samuel Hahnemann, developed homeopathy. Hahnemann graduated in 1779, and shortly after started his medical practice. It is reported that by the 1780s he '*was becoming disenchanted with his chosen profession*' (Cook 1981, p.52). The reasons cited for this change in outlook include '*his belief that the tools he had been given would do more harm than good*' (Dancinger 1987, p.5), and in 1781 when Hahnemann was in Desau it is reported that '*he (Hahnemann) had followed the orthodox training of the day, with its insistence on powerful drugs, bleeding, blistering, but he soon grew first disillusioned, then appalled by the failure of these methods.*' (Cook 1981, p.52).

Hahnemann also needed to earn enough money to support his expanding family (Morrell 1999). As a highly proficient linguist, he finally gave up medicine in 1784, in

favour of translation work (Gumpert 1945), and quickly became a highly regarded translator of medical and scientific works (Morrell 1999). In 1790, Hahnemann, whilst translating William Cullen's materia medica, disagreed with Cullen's reasoning about the mechanism of action of cinchona in malaria. Hahnemann went on to take cinchona himself for several days, developing the symptoms of intermittent fever. As a consequence of this experiment, Hahnemann started to form his own hypotheses, many of which still remain as part of homeopathy practice.

In 1796, he published a paper entitled '*New principle of how to find the remedial powers of remedies*'. In this paper Hahnemann outlined his thoughts on the use of '*similars*', claiming that true medicine should be based on similitude (Hahnemann 1796). Hahnemann started to experiment by giving a range of substances to healthy volunteers, carefully recording any symptoms generated (provings). The idea of experimenting on healthy people had already been instigated by Von Haller (1771, p.12) who stated that:

*'Indeed, a medicine must first of all be essayed in a healthy body, without any foreign admixture; when the odour and taste have been examined, a small dose must be taken, and attention must be paid to every change that occurs, to the pulse, the temperature, respiration and excretions. Then, having examined the symptoms encountered in the healthy person, one may proceed to trials in the body of a sick person'*

This concept formed an important basis in homeopathy and is found in footnote to aphorism 108 in the Organon (Hahnemann 1810) described as:

*'Not one single physician, as far as I know, during the previous 2,500 years, thought of this so natural, so absolutely necessary and only genuine mode of testing medicines for their pure and peculiar effects in deranging the*

*health of man, in order to learn what morbid state each medicine is capable of curing, except the great and immortal Albrecht von Haller. He alone, besides myself, saw the necessity of this. But no one, not a single physician, attended to or followed up this invaluable hint. {vide the Preface to the Pharmacopoeia Helvetica, Basil, 1771, fob, p17}*

The substances chosen for experimentation were those found amongst the conventional medicines of the day (Morrell 1994). Hahnemann was trying to establish a '*physiological doctrine of medical remedies, free from all suppositions, and based solely on experiments*' (Gumpert 1945, p.92). What he found, according to Morrell (1994), was '*incredible and undreamt-of detail*' and formed one of the major tenets of his therapeutic approach. It is these symptoms that form '*drug pictures*' which then become incorporated into the homeopathic materia medica along with toxicological and clinical reports.

The popularity of homeopathy spread throughout Europe, and eventually into the United Kingdom (UK). It is important to consider homeopathy's introduction into the UK in order to examine its subsequent development, as it is partly the manner of its introduction and subsequent use that has contributed to the unique position occupied by homeopathy in modern health care systems in the UK.

In the 1830's Dr Quin (1799-1878) started to promote the use of homeopathy in the UK. Quin was a physician to a number of wealthy, aristocratic families and met Hahnemann during a visit abroad, apparently curing himself of cholera, and treating his asthma with homeopathy (Haehl 1922). Quin established homeopathy as a mode of treatment amongst such dignitaries as Dickens, Thackeray and Landseer, amongst others. With such patronage, homeopathy quickly became fashionable,

counting many members of the royal family amongst its users (Morrell 1998). At its peak, there were around 155 homeopathic dispensaries in the UK with a homeopath and herbalist in every town (Morrell 1998). In comparison there are now only seven dedicated homeopathic pharmacies (Homeopathic Medical Association 2013), and around 2000 homeopaths. In 1843 Quin founded the British Homeopathic Society (partly as a response to vitriolic attacks on homeopathy). In 1850, he set up the London Homeopathic Hospital (Young 2008). According to Morrell (1998), Quin used his many contacts and influence to alter the 1858 Medical Act (The Medical Act 1858). The Act went ahead with a clause enabling the Privy Council to remove the right from any university to award degrees if it attempted to determine the type of medicine practised by its graduates. This meant that homeopathy was never considered unacceptable and was left largely unchallenged by the establishment (Inglis 1964). The manner of homeopathy's introduction also ensured that it remained exclusively within the medical domain and with upper class patronage despite attempts by various groups to popularise it amongst the British lower classes (Morrell 1998). It was only with the decline of homeopathy in the early 20th century that a small group of doctors decided to teach some non-medically qualified (lay) homeopaths. These lay homeopaths went on to teach others and as a result established the tradition of professional homeopathy in the UK.

It wasn't until 1978 that the lay practitioners formed the Society of Homeopaths (SoH), establishing for the first time, a College, a Register (SoH 2013b), a Journal (SoH 2013c) and a Code of Ethics (SoH 2013a). The Society of Homeopaths started with 15 members in 1979, and now has in excess of 1,600 members (Duckworth, *et al* 2011, SoH 2013b). At the peak of the resurgence of homeopathy in the late 20<sup>th</sup> century there were 22 colleges. Of these only ten remain (Society of Homeopaths 2013).

Meanwhile, the homeopathic hospitals were assimilated into the NHS at its inception in 1948. Nye Bevan provided an assurance that the homeopathic hospitals would be able to continue to maintain their approach to treatment and provide homeopathic treatment to patients (Society of Homeopaths 2008). In 1950 The UK Faculty of Homeopathy was incorporated by an Act of Parliament allowing the Faculty to regulate the education, training and practice of homeopathy within the medical and associated professions. In 1974 government commitment to homeopathy in the NHS was confirmed when Dr Owen stated that the existing policy to homeopathy was in no way altered by the National Health Service Reorganisation Act 1973. The government accepted the obligation to provide facilities for this type of medicine whilst there were doctors willing to practise it and while there was a demand for it (Owen 1974). Notwithstanding this commitment towards and indeed demand for homeopathy, the practice has always struggled to attain legitimacy amongst some parts of the medical and scientific communities (Headland 1858, Eyles 2009).

## **2.9 Types of homeopathy**

Homeopathy is a complex intervention, possessing as it does multiple components (Bell 2005, Boon, *et al* 2007). According to Thompson and Weiss (2006, p.1) these components include the patients' *'openness to the mind-body connection, consultational empathy, in-depth enquiry into bodily complaints, disclosure, the remedy matching process and the actual remedies'*. There are also, however, a number of different styles of homeopathy practised, including classical, complex and clinical homeopathy.

*'Classical homeopathy'*, which can also be referred to as *'individualised'* or *'constitutional homeopathy'*, is the term used when describing the use of single remedies with a careful observation of its effects and making adjustments as required. This is the form of homeopathy that purports to treat the patient not the disease (Fisher 2012). A full case history is taken and the remedy that best matches the patient and their individual expression of disease is chosen. This means that it is possible to have a number of patients with the same disease being prescribed different remedies. The patient is often given the medicine in a highly potentised<sup>4</sup> single dose.

*'Complex homeopathy'* involves prescribing more than one remedy at the same time or several potencies of the same remedy in the same prescription. Some homeopaths choose to do this, and there are some commercial complex remedies available as over the counter remedies.

*'Clinical homeopathy'* also referred to as *'therapeutic homeopathy'*, has its origins in France, although has also been favoured in the United Kingdom by homeopaths such as Douglas Borland (1885-1960). The approach uses the same basic principles as other styles of practice, but pathological symptoms are afforded more importance, with less emphasis placed on the constitutional and emotional symptoms. Clinical homeopathy approaches the medical diagnosis in a similar way to conventional medicine. Homeopathic remedies are generally prescribed more frequently and in a lower potency to those prescribed where the classical approach is favoured (Fisher 2012).

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<sup>4</sup> Potentised: a process of serial dilution and succussion used by homeopaths to increase the strength of the remedy.

The practice of homeopathy is situated within a model of health and illness that is viewed as an alternative to conventional medicine (House of Lords Select Committee 2000). Within this, homeopathy possesses its own set of core principles and values (Adams 2009). An important aspect of classical homeopathy lies in its appreciation and use of the therapeutic relationship. Although in recent years an understanding of models of the therapeutic relationship has been included in the homeopathy curriculum in the United Kingdom, this has not always been the case (SOH 2010, 2011). This is not to say that homeopaths do not have a model, they do, and although I would argue this is implicit, it develops through an appreciation of '*The Organon*' (Hahnemann 1810), the values held by students and practitioners and through the development of case taking skills. It is important to note that homeopathy is neither counselling nor psychotherapy. Adams (2009) considers that whilst there may be some overlap between psychotherapy and homeopathy there are some very important differences between the two. He considers that psychotherapy is predicated on a different model for understanding human beings and uses very different treatment methods. Areas of overlap between psychotherapy and homeopathy lie in the requirement for good listening skills and the recognition of the desirability of supervision for its practitioners. He goes on to explain that the task of the homeopath is to learn about the patient through their personal narrative and by observation, subsequently relating these to our knowledge of remedies. Homeopaths and psychotherapists have different ways of '*seeing*' the person because they have different approaches to healing. So whilst there are similarities, and skills that can be learnt from counselling and psychotherapeutic approaches, there are also fundamental differences.



The type of homeopathy used in pregnancy and birth will often depend on the nature of the complaint, when in pregnancy the consultation takes place, and the preference of the homeopath and patient. The approach used may also vary depending on whether the mother is already receiving on-going treatment or seeking symptomatic relief of symptoms. Homeopathy is currently classified in the United Kingdom as a complementary and alternative medicine (CAM), however defining CAM is a complex task as the definition covers a large array of health care practices. The National Centre for Complementary and Alternative Medicine (NCCAM) provides a widely accepted inclusive definition of CAM as a '*group of diverse medical and health care systems, practices and products that are not generally considered part of conventional medicine*' (NCCAM 2012).

The House of Lords Select Committee on Science and Technology Sixth Report (2000), broadly concurred with this definition, whilst providing further clarification, noting that whilst some CAMs are only able to provide what is best described as adjunctive support; others are able to offer complete systems of assessment and treatment. The report recognised that some therapies were well regulated with the beginnings of an evidence base, whilst others were not. The House of Lords proposed that CAM therapies be divided into three groups. Group One includes the five '*principal professions*' of which osteopathy and chiropractic are statutorily regulated, whilst herbal, homeopathy and acupuncture were described as having robust systems of self-regulation. Group One therapies are often termed the '*Big Five*' in the CAM world, and are defined as having individual diagnostic approaches. Group Two therapies do not include diagnostic skills, and include therapies such as aromatherapy, massage, counselling, hypnotherapy and reflexology. Group Three includes the remaining therapies that, according to the Select Committee, lacked

any credible evidence base. This includes anthroposophic medicine<sup>5</sup>, ayurvedic medicine<sup>6</sup>, Chinese herbal medicine, naturopathy<sup>7</sup>, crystal therapy<sup>8</sup>, dowsing<sup>9</sup>, iridology<sup>10</sup>, kinesiology<sup>11</sup> and radionics<sup>12</sup>.

## 2.10 The homeopath

Traditionally, homeopaths in the UK were medically qualified, however with the decline of homeopathy in the early 20<sup>th</sup> century a small group of doctors took it upon themselves to teach a group of non-medically qualified (lay) homeopaths who went on to teach others and in doing so, established the tradition of professional homeopathy in the UK. The Society of Homeopaths started with 15 members and now has in excess of 1,600 (Duckworth, *et al* 2011, SOH 2013b). At the peak of its recent popularity in the 1990's there were 22 colleges. In 2013 this number had reduced to ten (Society of Homeopaths 2013). A survey (SOH 2006) reveals that homeopaths in the UK Society of Homeopaths are mainly female, over the age of 45, have been in practice over five years and seeing between five and ten patients a week. Whilst professional homeopaths join a registering body such as the Society

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<sup>5</sup> Anthroposophic medicine is an extension to conventional medicine, developed from the work of Rudolf Steiner and Ita Wegman. It adopts a holistic approach and looks not just at the illness but at the human being as a whole. It aims to stimulate the natural healing forces of the individual and to bring mind, body and spirit in balance. Both medicines and therapies are used to achieve this <http://www.weleda.co.uk/about-weleda/anthroposophic-medicine/stry/subcategorytitle05>

<sup>6</sup> *Ayurvedic medicine* (also called Ayurveda) is one of the world's oldest medical systems. It originated in India more than 3,000 years ago and remains one of the country's traditional health care systems. Its concepts about health and disease promote the use of herbal compounds, special diets, and other unique health practices.

<http://nccam.nih.gov/health/ayurveda/introduction.htm>

<sup>7</sup> naturopathy: the treatment of illness by using diet, herbs, exercises, etc., without using standard drugs or surgery <http://www.merriam-webster.com/dictionary/naturopathy>

<sup>8</sup> Crystal therapy is a gentle non-invasive form of alternative healing that works holistically to harmonise the mind, body, emotions and spirit, helping to increase our feeling of well-being, neutralise negativity, lift depression and to help us to become integrated, whole beings. <http://www.crystalwellbeing.co.uk/introcrystalhealing.php>

<sup>9</sup> To dowse is to search, with the aid of simple hand held tools or instruments, for that which is otherwise hidden from view or knowledge. It can be applied to searches for a great number of artefacts and entities. <https://www.britishdowsers.org/learn/>

<sup>10</sup> Iridology is the study of the iris, or colored part, of the eye. This structure has detailed fibers and pigmentation that reflects information about our physical and psychological makeup. It identifies inherited dispositions (how our body reacts to our environment and what symptoms to expect), and future challenges (where we are likely to have more problems as we age). It also helps identify inherited emotional patterns, which can create or maintain physical symptoms, as well as identify lessons or challenges and gifts or talents available to us <http://www.iridologyassn.org/>

<sup>11</sup> Systematic Kinesiology (Kin-easy-ology) uses simple, safe and precise muscle testing procedures to find imbalances within the body that then either have or would become symptoms. With Kinesiology we can get to the cause or root of the problem which may be physical, chemical, emotional or energetical. Kinesiology uses specific massage points, nutrition, energy reflexes and emotional techniques to balance the person as a whole. <http://www.kinesiology.co.uk/info.php>

<sup>12</sup> Radionics is a healing technique in which our natural intuitive faculties are used both to discover the energetic disturbances underlying illness and to encourage the return of a normal energetic field that supports health. It is independent of the distance between practitioner and patient.

of Homeopaths, the Alliance of Registered Homeopaths or the Homeopathic Medical Association, statutorily registered health professionals trained in homeopathy may also register with the Faculty of Homeopathy.

As identified, homeopathy has a long tradition in the United Kingdom. However, like the majority of health care practices, it is influenced by the wider sociological and political frameworks it interacts with. In homeopathy there is an on-going debate surrounding the interpretation of evidence. The next section of the chapter examines this debate, and the impact that it has on the attitudes towards homeopathy.

## **2.11 Evidence-based medicine**

EBM in its current form developed in the early 1990's when a number of physician-researchers (Evidence Based Medicine Working Group, EBMWG 1992) urged doctors to form their clinical decisions on rational calculation and research rather than expert opinion or intuitive judgements. Sackett (1996, p.71) defined EBM as:

*'the integration of clinical expertise, patient values, and the best evidence into the decision making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal and unique concerns, expectations, and values. The best evidence is usually found in clinically relevant research that has been conducted using sound methodology.'*

The amalgamation of large amounts of clinical trial data into manageable systematic reviews or meta-analyses was intended to transform medical practice and offer impartial and politically transparent criteria for the choice and funding of treatment

(Chatfield 2007). It states that practitioners should use results from clinical trials to guide their decisions and actions in practice. Practitioners are advised to exclude peer discussions, experience and intuition as the only basis for decisions and actions in medical practice. Figure two demonstrates this by the use of a pyramid where the base is made up of expert opinion, moving gradually up to systematic reviews/meta-analyses, which are deemed to supply the best quality of research evidence. NICE guidelines have also adopted this model. Prior to the advent of EBM, clinicians used a multi-pronged approach to clinical decision-making. The differences between the two approaches can be clearly identified with the traditional approach favouring both personal and collegial knowledge and experience, and EBM advocating a more objective population based approach.

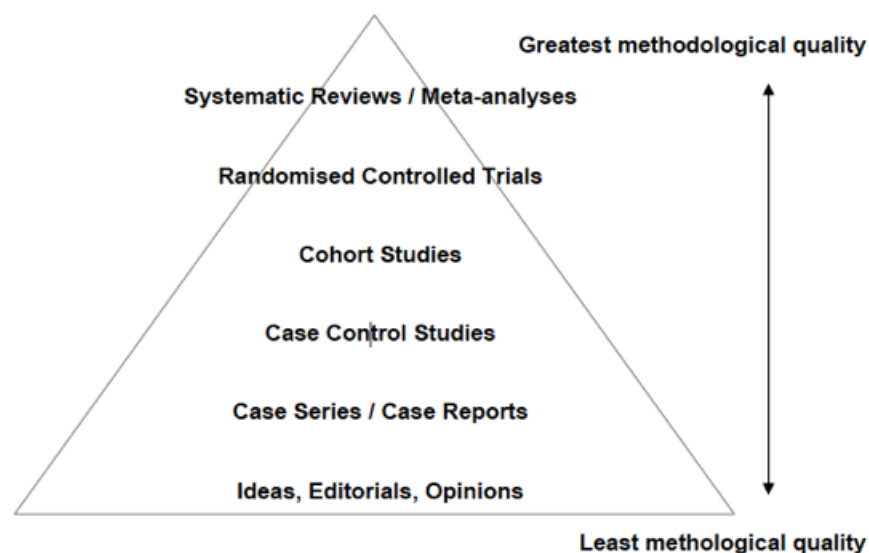


Fig 2: Shropshire Health NHS Libraries: Levels of evidence in healthcare.

### 2.11.1 Emergence of Evidence Based Practice

Over the years the term Evidence Based Practice (EBP) has emerged as a variant of EBM, not least in areas such as nursing, midwifery, social work and education (Banning, 2005). This change of terminology reflects the extension of evidence based medicine into these areas of practice, although Banning argues that there is '*remarkable variation*' (Banning 2005, p.411) in nurses understanding of the concept. However, Hoffmann *et al* (2010, p.18) in examining EBP across the professions base their understanding of EBP on Sackett's definition of EBM. Their definition states that EBP '*acknowledges that it involves the integration of the best research evidence with clinical expertise and the client's values and circumstances*'. They take care to stress the importance of including '*clinical expertise*' which includes '*thoughtfulness and compassion as well as effectiveness and efficiency*'. Driever (2002, p.593) definition similarly contains patient preference and clinical expertise, but also includes '*the synthesis of knowledge from research; data analysed from the medical record; quality improvement and risk data; infection control data; international, national and local standards; pathophysiology; cost effectiveness analysis; and benchmarking*.' Whilst these wider definitions are welcome and used in midwifery, homeopathy typically remains evaluated using traditional EBM principles, and these place greater value on the systematic review and randomised controlled trial.

### 2.11.2 Midwifery and evidence-based practice

Homeopathy is not alone in holding a discourse around the current definitions of evidence-based medicine/practice and its application. Despite the move towards evidence based practice similar debates occur in midwifery. In part this is believed to result from the professional conflict between the midwifery and obstetric models

of care (Bogdan-Lovis & Sousa 2006). This would appear to be comparable to the debates held between homeopathy and biomedicine. However, unlike the homeopathy profession where there is widespread opposition to the use of a simple hierarchical approach to evidence, there is a greater variation in the views held by midwives. Straus and McAlister (2000) cite a number of concerns about EBP in midwifery. In particular, Strauss and McAlister (2000) note an absence of evidence about the utility of EBP in midwifery, as well as the concern that its use can lead to fewer choices for low risk women, and neglect those with complex needs. They also question whether it affects midwives resourcefulness, reduces autonomy and impacts on legal proceedings. In conclusion they ask whether the use of EBP means the exclusion of useful forms of evidence, which do not appear at the top of the hierarchy of evidence.

Hofmeyer (2005), raises a different type of concern, one about the fundamental beliefs held by midwives, and describes how some midwives hold the view that childbirth is a natural process, requiring little in the way of intervention, whilst others take the view that childbirth is a risky process requiring intervention. Stewart (2001) argues that these views spill over into what those individuals understand about what constitutes '*evidence*'. She argues that the term is '*value laden*', and that there is a huge variation about what constitutes '*good evidence*'. In order to explore this, Stewart interviewed ten midwives, two obstetricians and a research nurse. She found a diverse range of opinion amongst the participants. Each participant had constructed a definition of '*evidence*' that best reflected his or her own particular interests. However, the research also revealed that the dominant culture of the health service affected the interpretation of '*evidence*'. Notions of professional control and authoritative knowledge inherent within a cultural ethos were automatically incorporated into domains of practice. Stewart, citing the work of

Kirkham, stated that any practice, evidence-based or not, that failed to meet the accepted cultural norms was seen as deviant, and therefore subject to criticism and scapegoating. This practice, she argued could result in professional acceptance that the '*only good and reliable evidence is that which maintains cultural norms*' (Stewart 2001, p.287). This leads on to Traynor's (2002, 2003) view of the resemblance between the push for EBM and a new religious movement. In particular Traynor notes the use of charismatic leaders and evangelistic features in both new religious movements and EBM. This Traynor argues, results in those who believe in EBM and the unconverted. It is not until a later stage in its development that a critical evaluation takes place.

### **2.11.3 Critique of Evidence Based Medicine/Practice**

Views on the utility of EBM are diverse. Proponents have described it as a '*paradigm shift*' that will change medical practice in the years ahead (Guyatt and Rennie 2002). By using evidence that is considered to be consistent and impartial, EBM purports to introduce rational order into decision-making in healthcare. Supporters even go as far as to state that doctors who fail to use EBM should face suspension of their medical licenses. (Muney, 2002). Others adopt a more sceptical stance believing that there is no evidence to suggest that EBM enhances care, and that it is simply '*following its own political agenda*' (Goodman 1999. P.249). Lambert, *et al* (2006, p.2613) consider that EBM has been awarded a '*symbolic authority*' in modern healthcare practice, whilst Charlton (2009, p.930) considers EBM to exert its own '*coercive power*'. He describes EBM as '*uninformed, confused and dishonest*' stating that in his view it is '*reanimated from the corpse of Clinical Epidemiology*'. He believes that it only continues its existence owing to its '*incessant pumping of funds*'.

Brase (2008) believes that EBM is ultimately about the adoption of standardised rather than individualised care. In essence, rather than acknowledging the 'art' of medical practice there is the desire to align medicine with care that is evidenced using population based evidence (Miettinen 2001). This position assumes that subjective clinical impressions are misleading and overestimate the effectiveness of care, including as they do the placebo effect. According to Walach, *et al* (2006) EBM has at its core the randomisation of a sufficiently large group of participants to control and treatment groups, so evenly distributing known and unknown confounding variables. Any changes in the outcome of patients can then be attributed to the medicine or intervention.

As a consequence, as much as EBM has been lauded as one of the main developments in healthcare, it has also been criticised as a movement that will straightjacket professionals and reduce autonomy (Mullen and Streiner 2004). Rosoff (2001), states his concern that Clinical Practice Guidelines derived from EBM could result in a 'cookbook' style of medicine that turns doctors into robots by removing their ability to use their professional skill and judgement. Tanenbaum (1993) believes that other forms of evidence such as clinical knowledge are indispensable to clinical decision-making, and by relying solely on EBM healthcare practitioners are failing to utilise valuable knowledge. Kerridge (1998, p.1153) noted that:

*'..the large quantities of trial data required to meet the standards of evidence based medicine are available for very few interventions. Evidence based medicine may therefore introduce a systematic bias, resulting in the allocation of resources to those treatments for which there is rigorous evidence of effectiveness or toward those for which there are funds available to show effectiveness (such as new pharmaceutical agents'.*



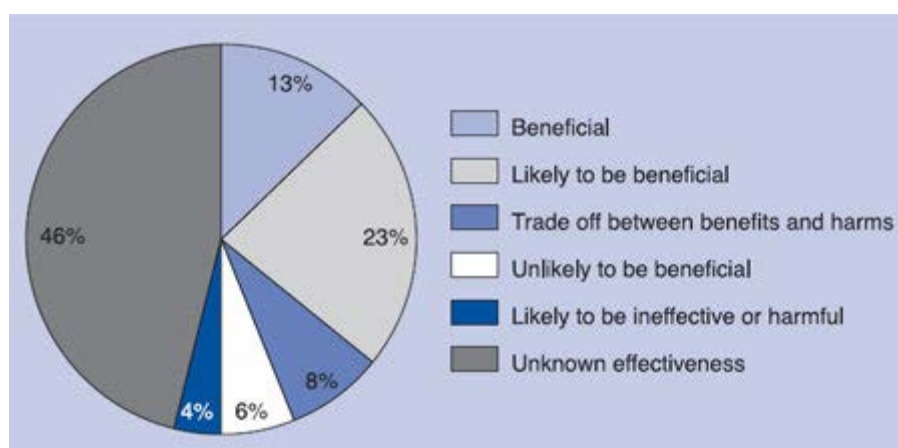
Similarly, Belkin (1997, p.513) cautioned that bias and values are just as evident in EBM as in traditional approaches to care, stating that:

*'Techniques that people see as objective proof, when more carefully examined, are easily seen to be the result of a multitude of subjective choices (my subjectivity of objectivity). Health services research and the foundational practices of managed care that....appear to offer new scientific rigor to medicine are a perfect example of this'.*

Kerridge (1998, p.1153) notes that by engaging solely with the EBM paradigm it is possible that in areas where there is less rigorous evidence or where evidence is not attainable a situation may be reached where a therapy '*without substantial evidence*' is believed to be a therapy '*without substantial value*'. Goldenberg (2005, p.6) adds that any '*model that represents biomedicine's power as disinterested (or even merely scientific) should give pause for thought*'. This is especially so, states Goldenberg, in an era where medicine is seen as a powerful institution. When problems with biomedicine are put down only to difficulties with evidence, biomedicine is left unchallenged. He considers that the belief of some, that by '*relying on the facts*' or '*the evidence*' to arbitrate between rival clinical practises or scientific beliefs will lead to '*transparent, neutral, objective and universal*' standards, oversimplifies the issue and is no longer a reasonable position to adopt in science (Goldenberg 2006).

Indeed, there are major gaps in EBM for a very large percentage of clinical procedures. For example, audits have shown that, of the procedures carried out in Accident and Emergency Departments (A&E) 40-50 percent have no evidence base (Harden 2003). Similarly in paediatric surgery 89 percent of interventions have no

RCT evidence (Kenny, Shankar, Rintala *et al* 1997). Garrow (2007, p.951) reviewed which of the 3000 treatments included in Clinical Evidence fell into a series of categories, including: '*beneficial, likely to be beneficial, trade-off between benefits and harms, unlikely to be beneficial, likely to be ineffective or harmful, unknown effectiveness*'. The chart (Fig 3) is replicated below, illustrating that of the 3000 treatments included, 51% fall into the '*unknown effectiveness*' category. The unknown category includes areas where it is difficult to conduct RCTs or for where the evidence base is still evolving. The researchers reported that the data reflects how treatments stand up in the light of evidence-based medicine (Garrow 2007).



**Figure 3: Percentage of treatments likely to be beneficial (Garrow 2007).**

By 2009 Kaplan (2014) reported revised figures, with only 11% of treatments now considered to be beneficial, with those falling into the category of unknown effectiveness rising from 46% to 51%. This would suggest that despite the drive towards evidence-based practice, the number of treatments conducted without clear evidence is increasing.

Underpinning EBM is the theoretical construct that the world can be made increasingly knowable by empirical enquiry. Positivism, under these conditions, is

closely aligned with 'scientism' (Milgrom 2012). Embracing a positivist stance means adopting certain beliefs about the way that information about phenomena should be collected, studied and used. In the positivist paradigm phenomena are both observable and measurable, and science is seen as a way of getting to the truth. Milgrom and Chatfield (2012) describes EBM in the 21<sup>st</sup> century as a '*inquisitional monoculture*' relying only on the RCT and ignoring evidence from patients and physicians, far removed from its original intention as '*an approach to health care that promotes the collection, interpretation, and integration of valid, important and applicable patient-reported, clinician-observed, and research-derived evidence*' (Cochrane Library 2014). Fuchs (1992, p.1) in describing the worldview that embraces EBM states that:

*'the privileged status of scientific knowledge reflects the sacred role science plays in the public discourse of modern society and culture. Ever since the Enlightenment equated science with societal progress and moral emancipation from tradition and superstition, science has come to be viewed as the paradigm for all rational practice...The label 'scientific' lends special credibility and authority to knowledge claims and discursive practices and social groups try to mobilise science in support of their interest.'*

Tuteur (2009), an obstetrician and former clinical instructor at Harvard, wrote that whilst:

*'at the beginning of the evidence based practice movement, much of the midwifery profession responded enthusiastically to the potential for change. Evidence based practice was seen to be offering a powerful tool to question and examine obstetric-led models of care that had dominated the previous decades. The results of such examination could have meant 'starting stopping' the unhelpful interventions that had embedded themselves in common practice'*

Indeed, she now cautions about the dangers of believing that the current hierarchy of evidence used in evidence based medicine is the ideal. She states that although

evidence should guide decisions about treatment, there has been an excessive amount of third party influence on what counts as satisfactory evidence.

The literature clearly reveals a multitude of views to be held about the EBM hierarchy and its contribution to the generation of evidence to be used in practice. The next section of the chapter considers the debates concerning evidence-based medicine and evidence-based practice, firstly in homeopathy and then midwifery.

#### **2.11.4 Homeopathy and evidence-based medicine**

As discussed, there is a great deal of debate surrounding the use of evidence in homeopathy. To illustrate this debate I explore a range of interpretations placed upon the reviews of homeopathy. This is not an examination of the evidence for homeopathy in maternity care as this appears in chapter three. Instead, this chapter considers the way evidence is treated. According to the Faculty of Homeopathy, in addition to five comprehensive systematic reviews, there have also been 33 systematic reviews that examine named clinical areas. Of these, 10 show positive results, 16 are inconclusive, whilst the remaining seven show little or no evidence for homeopathy (Faculty of Homeopathy 2014). Of the 188 peer reviewed, randomised controlled trials conducted up to the end of 2011, 44% (n=82) demonstrated '*a balance of positive evidence*', five percent (n=10) showed '*a balance of negative evidence*', 47% (n=89) were non-conclusive and four percent (n=7) contained non-extractable data. Of these studies, 63 used individualised homeopathy whilst the remaining studies examined non-individualised homeopathy (BHA 2013). To contextualise this, Milgrom (2012) compared these data to an analysis of 101 systematic reviews of RCTs of conventional medicines which showed 44% positive reviews, seven percent where there was negative evidence and 49% where the evidence failed to support any conclusion.

From this, Milgrom concludes that homeopathy produces very similar results to conventional medicine and therefore should not be rejected on the basis of the negative results. The search also revealed four clinical outcomes studies that provide a useful contribution to what is known about homeopathy treatment (Sharples, *et al* 2003, Spence, *et al* 2005, Witt, Ludtke, Baur *et al* 2005, Rossi, *et al* 2009). Of these, the observational study carried out at Bristol Homeopathic Hospital (Spence, *et al* 2005) covered 6,500 consecutive patients with 23,000 attendances over six years, observing that 70% of patients stated that their health had improved with 50% stating that the improvement had been significant. The study found that improvements were most marked in childhood eczema, asthma and inflammatory bowel disease. Similar findings were found in an Italian study (Rossi, *et al* 2009), where a longitudinal observational study on the response to homeopathic treatment of all patients attending the clinic during a seven year period, concluded that 74% of patients reported some improvement, with respiratory, dermatological and gastrointestinal pathologies responding best. Least improvement was found where there were psychological problems. The study conducted by Sharples, *et al* (2003) examined the responses of 499 patients using homeopathy, acupuncture and manipulative therapies at the Royal London Homeopathic Hospital. They found that patients chose to explore CAM either because of their concerns about the side effects of conventional medicine or its ineffectiveness for their condition. Thirty two percent of the patients sought help for musculoskeletal problems, 14% for skin conditions, with the remaining conditions including hypertension, endocrine/metabolic disorders, pre-menstrual syndrome, symptoms of menopause, migraines/headaches, allergies, cancer, chronic fatigue syndrome, IBS, Crohn's disease, food intolerances, asthma, anxiety, depression and stress. Sixty seven percent of the participants reported that their main complaint was moderately or much improved, 19.5% that it was slightly improved, 13.5% reported a deterioration of symptoms and three percent expressed their symptoms were moderately or much worse. Patients also noted that their secondary complaints

(anxiety, stress, depression, pain, arthritis, skin and digestion) also improved with treatment. The final study was a prospective, multicentre cohort study of 3,981 patients undertaken by Witt, *et al* (2005). The study, carried out in Germany and Switzerland examined data obtained from 1,130 children and 2,351 adults who were first time visitors to the homeopath. The most common conditions consulted for were allergic rhinitis in men, headache in women, and eczema in children. The outcome measures used included physician and patient assessment using a scale of one to ten, and a quality of life outcome measured at baseline, 3, 12 and 24 months.

A particular difficulty when reviewing the literature is the variety of meanings attributed to '*homeopathy*'. This lack of clarity becomes apparent when searching using Medical Subject Headings (MESH) terms, as the only term available is '*homeopathy*'. It is indexed to homeopathic remedies, treatment by a homeopath, homeopathic principles and the system of homeopathy. This creates a problem when reviewing the evidence (Relton 2008, Chatfield 2011). An example of this was described by Relton (2008) who found the terms used interchangeably both in the systematic reviews of '*homeopathy*' (Shang, *et al.*, 2005; Kleijnen, *et al* 1991; Hill and Doyon, 1990), and in the reviews of systematic reviews of '*homeopathy*' (Ernst, 2002; NHS Centre for Reviews and Dissemination 2002). This ambiguity creates real difficulties when attempting to reach any conclusions about the usefulness of a particular study, and must be factored in when undertaking any examination of the systematic reviews of homeopathy.

The next section examines the responses to the large systematic reviews of homeopathy by its supporters and opponents. The fundamental differences

between supporters and opponents are revealed in their approach to the way evidence is generated.

#### **2.11.4.1 Systematic Reviews of RCTs in Homeopathy**

The chart overleaf identifies the five systematic reviews located. The Linde, *et al* (1997) review was revisited in 1999 (Linde, *et al* 1999).

Date	Authors	Title	Methodology	Conclusions
1991 <sup>13</sup>	Kleijnen, <i>et al</i>	Clinical trials of homeopathy	Of 105 trials with interpretable results, 81 indicated positive result, whilst 24 showed no positive effects. The trials included classical homeopathy, non-individualised homeopathy and isopathy.	The evidence of clinical trials was positive but not sufficient to draw definitive conclusions owing to the low methodological quality of the trials and unknown publication bias.
1997 <sup>14</sup>	Linde, <i>et al.</i>	Are the clinical effects of homeopathy placebo effects? A meta-analysis of placebo-controlled trials.	119 trials out of 186 found, were identified as meeting the inclusion criteria and of these 89 were found to have adequate data for meta-analysis. The trials included individualised treatment, use of single or complex medicines and isopathic treatment.	Results were not compatible with the hypothesis that the effects of homeopathy are not completely due to placebo. The research team were unable to draw conclusions about the efficacy of homeopathy for any specific medical condition.
1999 <sup>15</sup>	Linde, <i>et al.</i>	Impact of study quality on outcome in placebo-controlled trials of homeopathy	Low quality trials were excluded.	They concluded that in the study set investigated, there was clear evidence that studies with better methodological quality tended to yield less positive results.
2000 <sup>16</sup>	Cucherat, <i>et al.</i>	Evidence of clinical efficacy of homeopathy – A meta-analysis of clinical trials.	Identified 118 randomised controlled trials. They selected the highest quality randomised placebo controlled trials (n=16) which included 2617 patients.	They concluded that it is likely that amongst the tested homeopathy homeopathic treatments at least one shows an added effect relative to placebo. They felt that the quality of the trials was low and this limited the reliability of drawing conclusions about clinical effectiveness.
2002 <sup>17</sup>	Ernst, E.	A systematic review of systematic reviews of homeopathy.	17 reviews articles met the inclusion criteria, including 6 re-analyses of Linde, Clausius and	The conclusion was drawn that these data do not provide sound evidence that homeopathic remedies are clinically different from

<sup>13</sup> Kleijnen, J., Knipschild, P. and ter Riet, G. (1991) Clinical trials of homeopathy. *British Medical Journal*. 302, 316-323

<sup>14</sup> Linde, K., Clausius, N. and Ramirez, G. et al (1997) Are the clinical effects of homeopathy placebo effects? A meta-analysis of placebo controlled trials. *Lancet*. 350, 834-843.

<sup>15</sup> Linde, K., Scholz, M., and Ramirez, G. *et al* (1999) Impact of study quality on outcome in placebo-controlled trials of homeopathy. *Journal of Clinical Epidemiology*. 52(8), 631-636.

<sup>16</sup> Cucherat, M., Haugh, M.C., Gooch, M. and Boissel, J.P. (2000) Evidence of clinical efficacy of homeopathy – A meta-analysis of clinical trials. *European Journal of Clinical Pharmacology*. 56, 27-33.

<sup>17</sup> Ernst, E. (2002) A systematic review of systematic reviews of homeopathy. *British Journal of Clinical Pharmacology*. 54, 577-582.



			Ramirez et al's original meta-analysis.	placebos. They acknowledged the potential publication bias as many of the included reviews were from the present author's team.
2005 <sup>18</sup>	Shang, <i>et al.</i>	Are the clinical effects of homeopathy placebo effects?	Compared 110 placebo-controlled trials of homeopathy and 110 matched trials of conventional medicine. Homeopathy and conventional medicine showed a similar positive effect overall. Twenty-one homeopathy trials and 9 in conventional medicine were considered of higher quality. From these the results of 14 unspecified 'larger trials of higher quality' (8 homeopathy, 6 conventional medicine) were analysed. Mean odds ratio was 0.88 (95 percent CI, 0.65-1.19) for the 8 homeopathy trials, and 0.58 (95 percent CI, 0.39-0.85) for the 6 trials of conventional medicine.	Weak evidence for a specific effect of homeopathic remedies, but strong evidence for specific effects of conventional interventions. The finding was compatible with the notion that the clinical effects of homeopathy are placebo effects.

Table 2: Systematic Reviews of Homeopathy (1991-2005).

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<sup>18</sup> Shang, A., Huwiler-Muntener, K, Nartey, *et al* (2005) Are the clinical effects of homeopathy placebo effects? Comparative study of placebo-controlled trials of homeopathy and allopathy. The Lancet. 366 (9487), 726-732.

It is the Shang, *et al* (2005) study that has been the topic of the most heated debate. Opponents of homeopathy claim that only the Shang, *et al* meta-synthesis has validity. In contrast supporters of homeopathy believe the '*Shang*' review to be fundamentally flawed. This debate is considered below.

#### **2.11.4.2 Exploring the '*Shang*' study**

As stated there have been extremely polarised views about the Shang, *et al* (2005) study depending on whether the reader is pro or anti homeopathy. The next section briefly introduces the study and examines the reason why it is claimed by the anti-homeopathy lobby to be the '*last word*' and by the pro-homeopathy lobby as '*fundamentally flawed*'. The Shang, *et al* study took the form of a meta-analysis, that statistically analyses a large number of results from a number of individual studies with the intention of integrating the findings into one generalizable study. Typically meta-analyses average the correlations across a number of studies examining the same topic. They are very highly regarded in EBM for determining the efficacy of an intervention. A particular difficulty when conducting a meta-analysis in homeopathy is the afore-mentioned lack of homogeneity of terms. As previously discussed this has an effect on the ability of systematic reviews to provide any real information about homeopathy's efficacy or effectiveness. Shang, *et al* (2005) is a prime example of this. It has also been criticised as being deeply flawed by the pro-homeopathy lobby for a number of reasons. One of the main reasons for this is that the study analysed 110 homeopathy trials and 110 matched conventional trials. The median study size was 65 participants (range 10-1573). Of a total of 220 trials the authors identified 21 homeopathy trials and eight conventional medicine trials that they considered to be of high quality. They continued with their analysis, selecting a small subgroup of the larger, high quality trials (8 homeopathy and 6 conventional) and from this drew their conclusions. They concluded that both the

smaller and lower-quality trials saw greater beneficial treatment effects than the larger and higher-quality trials when the analysis was restricted to large trials of higher quality (Reilly 2005). The interpretation was drawn that biases are to be found in all types of placebo-controlled trials including homeopathy and conventional medicine. When this bias was taken in account, there was '*weak evidence for a specific effect of homeopathic remedies, but strong evidence for specific effects of conventional interventions*'. The finding was considered congruent with the idea that the '*clinical effects of homeopathy are placebo effects*' (Shang, et al 2005, p.726). Reilly (2010) noted that 17 of the possible cut off points in the sub-analysis only three demonstrated a negative effect, and it was one of these three that the authors chose for their study. Their conclusions are based upon their belief that the '*placebo controlled randomised trial*' represents the standard by which all research should be measured. Subsequent to the Shang study, the BBC (2005) published an article titled '*Homoeopathy's benefit questioned*' writing that:

*'A leading medical journal, The Lancet (Shang, Huwiler-Muntener, Nartey et al 2005) made a damning attack on homoeopathy, saying that it was no better than dummy drugs. The Lancet said that the time for more studies is over and doctors should be bold and honest with patients about homoeopathy's 'lack of benefit'.'*"

The summary in the Shang, et al study (2006, p.726) stated:

*'homeopathy is widely used, but specific effects of homeopathic remedies seem implausible. Bias in the conduct and reporting of trials is a possible explanation for positive finds of trials of both homeopathy and conventional medicine and estimated treatment effects in trials least likely to be affected by bias'*

Of the five meta-analyses it is this negative study that has emerged as the most influential and often cited by individuals condemning homeopathy.

#### 2.11.4.3 Homeopathy and science

When considering the debate I reflect on the role of the skeptic movement. Those calling themselves ‘*skeptics*’ are perhaps the most vociferous opponents of homeopathy. Bond (2013) previously a part of the skeptic movement describes how skeptics ‘*portray themselves as an embattled minority standing up for science, the lone redoubt of reason in an irrational world, the vanguard of the old order of ignorance and superstition.*’ He describes how skepticism is underpinned by neoliberalism and hence scientism. Of homeopathy, Lewis (2014), a skeptic states

*Homeopathy is based on the 200-year-old pre-scientific and magical ideas of Samuel Hahnemann. Homeopaths study his works as if they were religious texts and follow his rituals and beliefs despite their utter implausibility and detachment from reality. Homeopathy is a pseudo-medical cultish belief system, a simulacrum of medical care, and crucially missing the essential ability to be able to make specific positive health improvements in their customers. Whilst homeopaths may have the intention to act as health providers, their beliefs make them systematically incompetent and a threat to the well being of those they practice on. At best homeopathy is a lifestyle choice for some, not a healthcare profession. Accrediting homeopaths would be like letting air guitarists join the Musicians’ Union.*

Whilst Laurence (2012) states:

*‘(Homeopathy) disregards most of what we know about physiology. It is in contrast with the laws of physics, chemistry and pharmacology. Homeopathy is thus biologically implausible’*

However, similar debates concerning the implausibility and lack of evidence in homeopathy occurred as long ago as the 1840’s. Forbes (1846, p.38) denounced homeopathy as being ‘*ludicrously absurd*’. The reasoning behind this opposition is

the belief that the principles of dilution and succussion<sup>19</sup> in homeopathy appear to be biologically implausible; therefore to accept that homeopathy works is to question what are currently considered to be the fundamental principles of science. Therefore, a person who is considered to be rational does not accept that homeopathy can work, despite any empirical evidence to the contrary. Madeleine Ennis, a homeopathy sceptic, and professor of pharmacology at Queen's University, Belfast, was challenged by a presenter at a conference to conduct a series of experiments examining the effects of ultra-dilute solutions of histamine on human white blood cells involved in inflammation. Ennis was part of a group of independent research laboratories tasked with finding out if *'high dilutions of histamine have a negative feedback effect on the activation of basophils by anti-IgE'* (Ennis 2010, p.55). The results of her experiments into ultra-high dilutions were unexpected. Ennis did not expect a positive result from her experiments and indicated that *'we are unable to explain our findings and are reporting them to encourage others to investigate this phenomenon'*. She said that *'if the results turn out to be real, the implications are profound: we may have to rewrite physics and chemistry'* (Belon, et al 2004, p.188). However, Ennis also cautions more generally on the methodologies adopted and the poor standardisation between laboratories. She calls for further multi-centre research to *'solve what seems to be a never-ending story'* (Ennis 2010, p.55).

## 2.12 Conclusion

In this chapter I have set out the context for the study and provided an overview of the key debates surrounding midwifery and homeopathy. An understanding of this context is important before proceeding to an explanation of the midwives

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<sup>19</sup> Dilution and succussion describes a process of serial dilution and agitation used by homeopaths when preparing potentised homeopathic remedies.

experience of studying homeopathy and the impact of this on practise. I have explained the key debates of risk, choice and EBM/EBP and how these appear to lie in opposition to each other. This essentially means that midwifery is encompassed within a system fortified by neoliberal principles. Choice is one of the principles arising from neoliberalism, however an equally strong principle is that decisions should be made on the basis of a certain type of evidence. The use of EBM/EBP serves to restrict choice where interventions do not conform to a very narrow definition of evidence. Homeopathy is one of the therapies that has been highly criticised for lacking this type of evidence. Consequently, this has had an enormous impact on the ability of midwives to use homeopathy in their practise.

The next chapter is a literature review carried out to establish what is currently known about the clinical use, attitudes and use of homeopathy in maternity care and how this might inform the current study.

## **Chapter Three: Focused review of studies of homeopathy and midwifery.**

### **3.1 Introduction**

In the previous chapter I presented the background to this study using literature from a range of sources to set the context for this research. To inform the research I reviewed the literature both at the commencement of the research and then regularly throughout the period of research and writing up of the study. This ensured the capture of the relevant literature. In starting the research study I conducted a mixed-methods systematic review, and I open this chapter by outlining the reasons why I had chosen to conduct a systematic review in a phenomenological study. I then articulate the importance of carrying out a review of the literature when conducting a phenomenological study. The results from the systematic review are presented and I analyse the contribution and limitations of the work already conducted in this area. The chapter concludes with an identification of the contribution my study can make to what is already known in this area.

### **3.2 'Doing' a mixed-methods systematic review in a phenomenological study?**

Given that I am undertaking a phenomenological study it may seem counter-intuitive to conduct a systematic review as part of my literature review. However, I would like to articulate the reasons for choosing to complete a systematic review. As a method of reviewing the literature the systematic review emerged out of the evidence-based medicine stable (Jones 2004), and is considered to employ a *'rigorous and well-defined approach to reviewing the literature in a specific area'*

(Cronin *et al* 2008, p.39). Hemmingway (2009) states that unlike a more traditional narrative review, the systematic review methodology provides explicit detail about how studies are chosen, assessed and discussed. Initially restricted to reviewing quantitative studies, the systematic review is now used to examine either or both quantitative or qualitative research. In a mixed-methods systematic review the researcher can choose to use the most appropriate type of analysis for different categories of findings (Hemmingway 2009). I chose to use a systematic approach to searching the literature as a way of ensuring that I conducted a focused, thorough review.

### **3.3 The importance of the literature review**

There is debate about the best timing for reviewing the literature when conducting any research study. Holloway and Wheeler (2010) cite earlier researchers such as Glaser (2004), who believe that reviewing the literature too early in a project is inadvisable as it could directly influence the later empirical research. Holloway and Wheeler (2010) make the argument that often researchers come to research with prior knowledge, as in my own case, and therefore pre-conceptions will always exist. Smythe and Spence (2012, p.16), agree, and add that when undertaking a review of the literature for a hermeneutic study the reviewer stands '*at the crossroads of all their fore-understanding*'.

This means that in coming to the literature I already have a starting place or understanding of the topic, described by Heidegger as my '*fore-having*', which arises out of my '*drawnness*' towards the topic. In addition to this I also possess '*fore-sight*' and '*fore-conception*'. '*Fore-sight*' includes my ability to determine how I '*for-see*' my search for the literature, which authors or journals I might choose to



search for. Having '*fore-sight*' pre-shapes my decisions about how I prioritise my search and choose my reading, although it is possible to recognise this and take steps to forestall it. Lastly, in reviewing the literature Smythe and Spence (p.16) draw on their view that Heidegger's notion of '*fore-conception*' is '*the most dangerous aspect of understanding*', although they also believe this is the best way to do it. In possessing '*fore-conception*' I already have an idea about what I will meet, and the direction the research will take. I find myself in agreement with Holloway and Wheeler (2010), and Smythe and Spencer that I come to the topic with a potential for understanding, and that I am in possession of both '*fore-sight*' and '*fore-conception*'. However, even though I already had some thoughts about the study, I consciously remained open to the possibility of my '*fore-conception*' being challenged by my reading and findings, as indeed it was throughout my study.

Not everyone is in agreement with Glaser's (2004) statement that the literature should be reviewed towards the end of the study. Kamler and Thomson (2014) consider that reviewing the literature is an on-going process, citing Boote and Beile (2005: 3) that a substantive literature review is a '*precondition for doing substantive, thorough, sophisticated research*'. Kamler and Thomson (2014, p.28) use the metaphor of '*persuading an octopus into a glass*' referring to the process when working with literature(s). They suggest that the purpose of a literature review is to:

*'sketch out the nature of the field...relevant to the inquiry, possibly indicating something of their historical development, and identify major debates.... in order to....establish which studies, ideas and/or methods are most pertinent to the study, and locate gaps in the field, in order to create the warrant for the study in question, and identify the contribution the study will make.'*  
(p.28)

For Smythe and Spence (2012, p.16) a literature review is the opportunity to do much more than this in a hermeneutic study. The process of moving between a researcher's '*already-there*' understandings and those '*that may be seen or unseen in the text*' allows the researcher to grow their own understanding. I decided to undertake a substantive literature review at the start of the study, to engage in a continuous process of remaining alert to emerging literature, and to revisit my review at the end of the study to ensure that no relevant literature had been overlooked. This allowed me to find out what had already been written, but allowed me to move between my emergent research and the literature to develop my understanding.

### **3.3.1 Locating relevant papers**

I was already aware that research on this topic was limited, but wanted to employ a clear strategy whereby I could be sure that I had indeed captured all the relevant research. The approach taken is detailed in this chapter.

Before starting my review a preliminary search took place to identify the presence of any existing or on-going reviews to determine whether a new review is warranted (Centre for Reviews and Dissemination 2009). This was carried out using a range of databases including, The Database of Abstracts of Reviews of Effects; Cochrane Database of Systematic Reviews; National Institute for Health and Clinical Excellence; NIHR Health Technology Assessment; The Campbell Collaboration; Evidence; Evidence for Policy and Practice Information Centre and Medline. The only review located was the Cochrane review on homeopathy for induction of labour (Smith 2009).

There has been an explosion of information available online, which has meant that the methods of literature searching have had to develop to keep pace. Bates (1989, p.2) explains a range of revised search strategies designed to maximise search effectiveness. Instead of a single query matched to relevant databases, the searches are emergent, which involves following a '*berry-picking*' pattern instead of a '*single best retrieved set*'. Following this process, the current search included footnote chasing, citation searching, journal run/area scanning and author searching (Walsh and Downe 2005). A search was conducted in the '*Web of Knowledge*' using the 'MESH' terms, '*homeopathy + midwifery/nurse midwives*', '*homeopathy + pregnancy*', '*homeopathy + birth/parturition*', '*homeopathy + postpartum*'.

However, this search failed to pick up some known papers. As a result of this I decided to widen my search terms to, '*homeopathy(ic) + birth/childbirth/delivery*', '*homeopathy(ic) + intrapartum*', '*homeopathy(ic) + postpartum*', '*homeopathy(ic) + parturition*', and '*homeopathy(ic) + midwives/midwifery*'. The databases used included, '*AMED*', '*British Index of Nursing*', '*Embase*', '*Medline*', '*PubMed*', '*MIDIRS*', '*CINAHL*', '*BIOMED*', '*EBSCO*' and '*HomInform*'. Included studies were recorded using data sheets, allowing a systematic process to be utilised for the initial search (Appendix 7, p.341).

As well as searching the databases, I searched the indexed and non-indexed professional homeopathy journals. Searches were undertaken in '*Homeopathy*', '*The Homeopath*', '*Homeopathy in Practice*', '*The Journal of Alternative and Complementary Medicine*', '*Alternative and Complementary Therapies in Nursing*', '*Simillimum*', and '*Homeopathic Links*'.

These searches were completed using electronic data where possible, and, where this was not available, by hand searching. According to Armstrong, Hall and Doyle *et al* (2005) hand searching journals is a useful addition to the armoury when conducting reviews as it allows for studies to be included that might not be found through electronic searching methods. All dates available were searched.

Further Internet searches took place for information on conferences and collections of theses. Email contact was made with the European Council of Classical Homeopathy to establish if they were aware of any past or on-going research from member countries. The European Network of Homeopathy Researchers was also contacted as were the Homeopathy Research Institute in the United Kingdom. The review is divided into two sections: clinical studies designed to test the efficacy/effectiveness of homeopathic remedies; and attitudes and use of homeopathy within maternity practice.

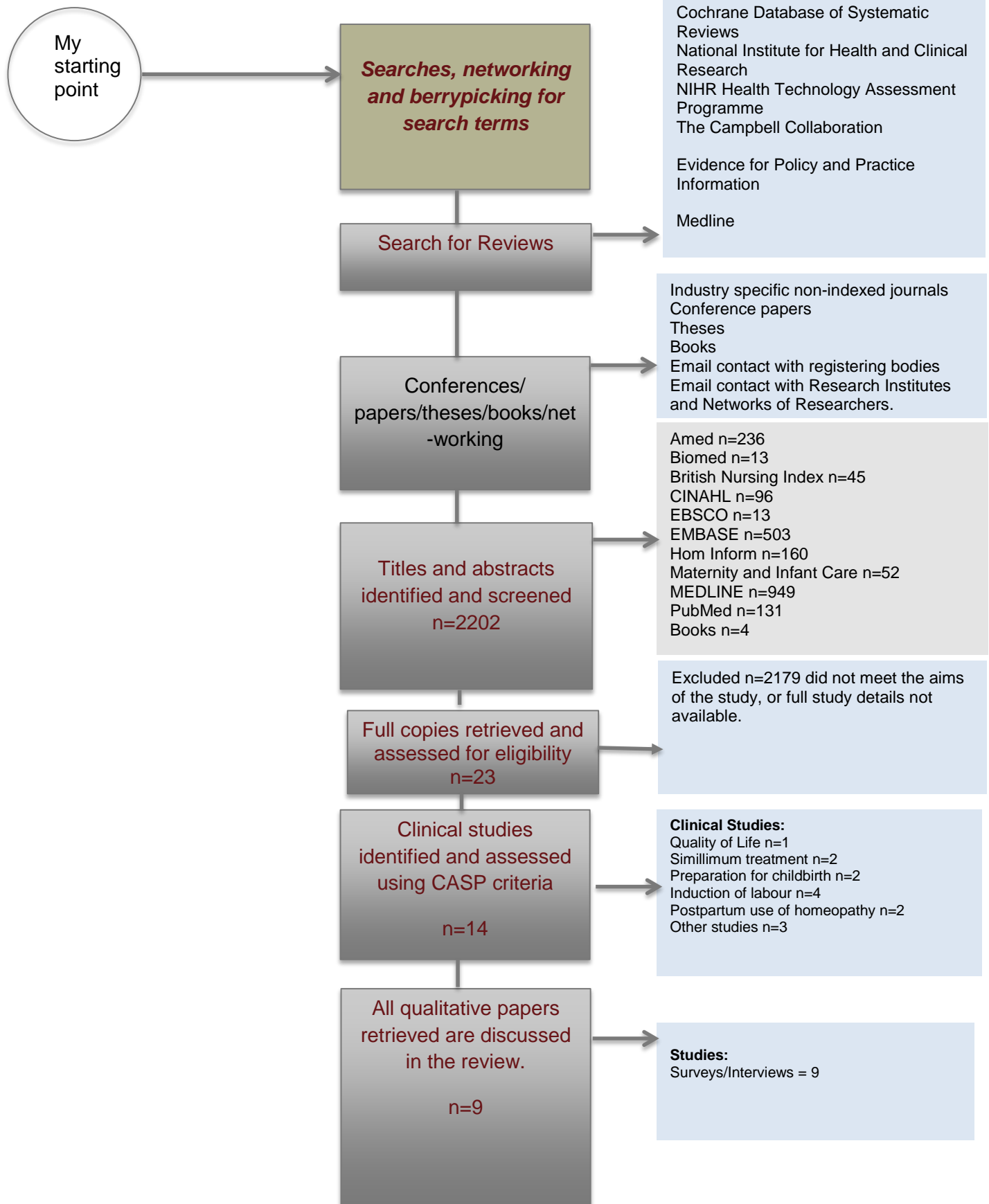
Inclusion Criteria	Exclusion Criteria
Clinical studies	
<ul style="list-style-type: none"> <li>• Focus on homeopathy (or where homeopathy is specifically included)</li> <li>• Full text articles</li> <li>• Qualitative and/or quantitative studies</li> <li>• Studies reported in English, German or French</li> <li>• Open dates</li> </ul>	<ul style="list-style-type: none"> <li>• Studies reporting CAM but where no specific mention of homeopathy</li> <li>• Studies where full text is not available</li> <li>• Literature on 'how to' prescribe homeopathic remedies.</li> <li>• Papers not published in English, German or French</li> </ul>

Table 3: Inclusion and exclusion criteria.

### **3.4 Results**

The results of the search can be seen in fig 4 (p.94). Two thousand, two hundred and two papers were identified. Duplicate studies were removed to avoid an over representation of the data (Crowther, *et al* 2010). Of the 2202 papers, 23 papers met the inclusion criteria. These included literature from academic and professional journals, theses and books, and were made up of clinical studies, qualitative studies and surveys.

Literature Search Strategy (Fig 4)



Overall a total of 23 papers were identified. Of these, 14 were clinical studies designed to test the efficacy/effectiveness of homeopathic remedies, nine were qualitative or quantitative studies exploring attitudes towards and the use of CAM/homeopathy in UK maternity settings. For easy reference an overview of the studies can be found overleaf. This details information about the researchers, country, participants, the question asked and conclusions drawn (Table 4).

The review is subsequently divided into two sections: attitudes towards and use of homeopathy in UK maternity care, and clinical studies examining the efficacy/effectiveness of homeopathy in maternity care.

<b>Literature on homeopathy in pregnancy, childbirth and post-partum.</b>				
<b>Author</b>	<b>Location</b>	<b>Participants</b>	<b>Question asked</b>	<b>Conclusions drawn</b>
<b><i>Interviews and Surveys (UK studies only)</i></b>				
Mitchell, <i>et al</i> (2006)	UK	Midwifery managers	Survey: provision of CAM in English maternity services.	43 percent of CAM units provided CAM care for staff. 34 percent provided CAM care to mothers, and 23 percent offered CAM care to babies.
Williams and Mitchell (2007)	UK	Midwifery managers and midwives.	Survey: Attitudes towards the integration and provision of CAM to staff, women and their babies in English maternity services.	Maternity unit managers and midwives felt that CAM benefited women by increasing choice, improving health and promoting normality.
Mitchell and Williams (2007)	UK	Role of midwife-CAM therapists	Interviews exploring the views of midwife-CAM therapists about the contribution CAM could make to support normal birth in England.	CAMs are used by midwives because of a personal belief in their efficacy and a disillusionment with conventional medical approaches.
Cant, <i>et al</i> (2011)	UK	Midwives and Nurses	In depth interviews examining the use of CAM by nurses and midwives in NHS hospital settings in 2008	Popularity in CAM had diminished since the 1990's, however its practice provided opportunities for committed individuals to enhance their practice. It was revealed though that CAM Integration did not afford autonomy, status and material gains normally associated with a collective professional project. CAM practitioners were often left vulnerable because the uncertain status of CAM knowledge, the limitation of midwives role by traditional medical authority and the lack of collective strategies.
Bishop, <i>et al</i> (2011)	UK	Service users	Survey examining the use of CAM in pregnancy.	Found that 26.7 percent of women had used CAM at least once during pregnancy. Herbal teas were the most popular (chamomile tea), followed by homeopathy (arnica, ipecac and calendula) and herbal medicine. 14.4 percent had used homeopathy.



Author	Location	Participants	Question asked	Conclusions drawn
Carter and Aston (2012)	UK	Service users	Survey of the use of homeopathic arnica among childbearing women	373 women agreed to participate, 228 returned questionnaires. 12 percent of these had used arnica. Of those using arnica 59 percent would have liked more information.
Cant, <i>et al</i> (2012)	UK	Midwives and nurses	Interviews examining the extent of integrative practice in UK NHS hospital settings	Qualitative interviews of and case studies with midwives and nurses. Eighteen telephone interviews and 9 face-to-face interviews. The study showed a history whereby there had been some initial success in integrating CAM this had been followed by a decline in service provision. Services were led by interested individuals, and this left them vulnerable in times of restricted funding and governance.
Jones, <i>et al</i> (2013)	UK	Service users	Survey of use of CAM in pregnancy	A descriptive questionnaire of 85 women, 40 of whom responded. Of these 40, 42.5 percent engaged with CAM. 27.5 percent had been offered CAM as part of their routine NHS care. 17.5 percent used CAM on the recommendation of their midwife, 12.5 percent used CAM by personal choice, and 7.5 percent encouraged by a friend or relative. In 27.5 percent of cases the maternity professionals were unaware of their use of CAM.
Mitchell (2013)	UK	Service users	Interviews exploring women's motivations and experiences of using CAM in pregnancy and childbirth.	In-depth interviews with 14 women in the Bristol and Wiltshire region. Participants had used a minimum of one CAM therapy in a past pregnancy and childbirth experience, were not pregnant or within 6 weeks of having given birth.
<b><i>Clinical Studies</i></b>				
<b><i>The use of homeopathic remedies during pregnancy, childbirth and postpartum.</i></b>				
<b>Quality of Life</b>				
Hochstrasser (1999)	Germany	Pregnant women	Quality of Life	Women who expressed a preference for homeopathic care judged their quality of life to be lower than those preferring conventional care.
<b><i>Simillimum (Individualised) treatment for specific conditions of pregnancy</i></b>				
Hutchinson (2006)	South Africa	Pregnant women	Treatment of haemorrhoids using individualised homeopathy.	83 percent of women improved, with a significant decrease in the severity of pain and protrusion. Further research needed.

Author	Location	Participants	Question asked	Conclusions drawn
Kruger (2007)	South Africa	Pregnant women	Treatment of pyrosis using individualised homeopathy treatment .	Improvement in the severity of pyrosis in all participants with 75 percent also experiencing improvement in the frequency of the pyrosis.
<b>Preparation for childbirth</b>				
Dorfmann, <i>et al</i> (1987)	France	Pregnant women	Homeopathy treatment for women with previous complications (hypertension, diabetes or previous caesarean because of abnormal foetal problem or virus)	Reduced average duration of labour (5.1 hours for homeopathy group vs 8.5 hours for placebo group). Reduced numbers of observed dystocias (11.3 percent for homeopathy group vs 40 percent for placebo group).
Ventoskovskiy (1990)	Russia	Pregnant women	Homeopathy treatment for mothers at high risk of uterine contractile function disturbances.	Prophylactic use of homeopathy for pregnant women at high risk of uterine inertia and postpartum haemorrhage is at least as effective as traditional prophylaxis.
<b>Induction of labour</b>				
Coudert-Deguillaume (1981)	France	Pregnant women	Caulophyllum for induction of labour	Positive result in favour of homeopathy (76.5 percent vs. 11.7 percent responding to homeopathy). False labour stopped in 6 out of 9 in the homeopathy group vs. 0 out of 11 in the control group. Dystocia was stopped in 7 out of 8 in the homeopathy group and 2 out of 6 in the control group.
Arnal-Lasserre (1996)	France	Pregnant women	Combination homeopathy remedy for induction of labour.	Duration of labour 5.1 hours in the homeopathy group vs. 8.48 hours in the control group. Dystocia reported in 11.3 percent of the homeopathy group vs. 40 percent in the control group.

Author	Location	Participants	Question asked	Conclusions drawn
Beer and Heiliger (1999)	Germany	Pregnant women	The trial considered the efficacy and tolerability of homeopathic Caulophyllum on the time interval from entry to the onset of regular uterine contractions. Other outcomes examined included duration of labour, oxytocin requirements, mode of delivery and the rate of maternal and neonatal infections.	The trial presented data on the baseline characteristics between the two randomised groups. No differences in weight, age, height, cervical score at trial entry and time since PROM were found between the study groups.
<b>Induction of labour – case report</b>				
Kistin and Newman (2007)	USA	Pregnant women –	Caulophyllum for induction of labour.	In combination with collective accounts and experiences case suggests that homeopathic remedies Caulophyllum and Cimicifuga may be effective at inducing labour with very few side effects.
<b>Other childbirth studies</b>				
Atmadjian, <i>et al</i> (1998)	France	Pregnant women in labour	Clinical effect of arnica for postpartum pain	The authors claim there were positive results, however owing to the small sample size there were not statistically significant.
Steen and Calvert (2007)	UK	Pregnant women towards end of pregnancy, childbirth and shortly after childbirth	Experience of using a 10 remedy homeopathy kit.	Women and birth partners reported positive benefit from using the kit.
Eid, <i>et al</i> (1993)	Italy	Pregnant women in first labour.	Applicability of caulophyllum in women in first pregnancy going into spontaneous labour	Reduction in length of labour by 90 minutes.

Author	Location	Participants	Question asked	Conclusions drawn
<b>Postpartum use of homeopathy</b>				
Oberbaum (2005)	Israel	Postpartum women	Arnica and bellis perennis on mild Postpartum bleeding	Arnica and bellis perennis may reduce Postpartum blood loss compared to Placebo.
Berrebi, <i>et al</i> (2001)	France	Postpartum women	Pain of unwanted lactation	Significant improvement in lactation pain in homeopathy group.

Table 4: Literature on homeopathy in pregnancy, childbirth and postpartum period

The next section of the chapter will consider those studies that explore attitudes towards, and the use of CAM/homeopathy by midwives and mothers, before moving on to a consideration of the second group of studies which were designed to ask clinical questions about whether or not; or how well homeopathy works for specific maternity related conditions.

As a result of the search nine academic papers were identified that focused on attitudes towards, and the use of CAM/homeopathy by midwives and mothers. After reading the papers I decided not to use a formal quality assessment tool, instead preferring to appraise each one fully. My inclusion criteria included only papers that showed the United Kingdom perspective. This resulted in each paper being relevant and able to provide insight into the phenomenon. I believed an assessment of these nine papers would make a credible contribution to the review (Pawson, et al 2005).

#### **3.4.1 Attitudes and use of homeopathy by midwives and women**

Each of the nine papers identified relating to attitudes and use of homeopathy by midwives and service users, are considered. The search strategy included open dates, however the papers identified were published within an eight-year time frame from 2006 to 2013. This reflects both a time of growth and increasing criticism of homeopathy. Table 5 overleaf outlines the studies using a thematic approach. A range of headings are used including: attitudes of NHS staff towards homeopathy; attitudes of women to homeopathy; the provision of homeopathy within NHS settings; the use of homeopathy by women; the use of arnica by women; the perceived benefits of homeopathy; constraining influences on the availability of homeopathy in the NHS.

Table 5: Studies examining attitudes towards and use of CAM in United Kingdom hospital settings.

<b>Authors and Paper</b>	<b>Population</b>	<b>Study design</b>	<b>Benefits for women</b>	<b>Benefits for midwives</b>	<b>Constraining factors</b>	<b>Enabling factors</b>	<b>Limitations of study</b>
Mitchell, <i>et al</i> (2006)	National survey of midwifery managers	Questionnaire to midwifery managers	Consumer satisfaction Promotion of normal childbirth Reducing medical intervention Improved quality of care	Promotion of normal childbirth Job satisfaction Improved quality of care	Funding Lack of practitioners Lack of knowledge Lack of time Concerns about competence Lack of evidence Fear of litigation	Safety Committed individuals Expert opinion Consumer demand Evidence from other units Research evidence Professional views Cost effectiveness	Midwife perspective only
Williams and Mitchell (2007)	National survey of midwifery managers	Questionnaire to midwifery managers	Choice Less intervention Personal satisfaction with birth experience Control Empowerment	Extension of role Positive feedback from service users Reduced sickness levels Sense of being valued where massage offered to staff	Lack of resources. Low priority. Lack of equity. No 24-hour service. Bureaucracy. Poor understanding of the benefits of CAM. Unsupportive medics and midwives. Lack of consensus. Lack of evidence. Questions about what constitutes a suitable qualification.	Motivation of staff Enthusiasm Managerial support Consumer demand	Views only of those staff sufficiently motivated to complete the questionnaire.

<b>Authors and Paper</b>	<b>Population</b>	<b>Study design</b>	<b>Benefits for women</b>	<b>Benefits for midwives</b>	<b>Constraining factors</b>	<b>Enabling factors</b>	<b>Limitations of study</b>
Mitchell (2007)	Eight midwife therapists (2 aromatherapists, one homeopath, one reiki practitioner and three reflexologists).	Semi-structured telephone interviews.	Complementary therapies seen as supporting normal birth. Provide alternatives Reduce medical intervention Empower women	Allows midwives 'to be with' women Enables holistic care	Midwives lack of autonomy	Not discussed	Midwife perspective only
Cant, <i>et al</i> (2011)	Midwives and Nurse CAM practitioners.	Two stage study. Stage one – interviews with eleven midwives and seven nurses across England and Wales. Stage two – case study in three district general hospitals in the southeast of England. Face to face semi-structured interviews with five nurse and four midwife CAM practitioners.	Filling effectiveness gaps. Congruence with normal birth. Lowers risk. Offers alternatives to a technology driven practice.	To augment midwifery practice. In response to dissatisfaction with bureaucracy. In response to dissatisfaction with technology driven practice. 'Risk' was used to map out practice territory. <sup>5</sup>	Lack of funding for training. Risk management and clinical governance regulations. Fear of litigation. No clear guidance on appropriate CAM qualifications for practice. Defining appropriate practice boundaries. Incompatible positions taken by biomedicine and CAM.	Enthusiastic, strong-minded individuals with a degree of personal authority. Skill in negotiating the social and bureaucratic context within a hospital. Natural leaders who take initiative, who are not afraid to take risks. Emphasis placed on the complementary nature of CAM treatments.	Considers CAM practice as homogeneous rather than heterogeneous practices.
Bishop, <i>et al</i> (2011)	Avon region Data available for 14,115 women	Postal self completed questionnaires by pregnant women at 8, 12, 18 and	As part of a strategy of self-care.	Not discussed	Not discussed	Not discussed	The data used in this study was collected between 1991 and 1992 and

		32 weeks gestation					may not reflect current use.
<b>Authors and Paper</b>	<b>Population</b>	<b>Study design</b>	<b>Benefits for women</b>	<b>Benefits for midwives</b>	<b>Constraining factors</b>	<b>Enabling factors</b>	<b>Limitations of study</b>
Carter & Aston (2012)	Survey of 373 English speaking postnatal women with healthy babies awaiting transfer to the community in a large inner London teaching hospital.	Self-completed questionnaire, designed to assess the use of arnica.	Not discussed	Not discussed	Not discussed	Not discussed	A convenience sample was used. Excluded non-English speaking women. Small-scale study that may not be generalizable. More likely to complete the questionnaire if they had used arnica. Inner-city London population.
Cant, <i>et al</i> (2012)	Same study as the 2011 paper above.	Same study as Cant <i>et al</i> (2011)	Reduction in reliance on technology. Offered where conventional medicine had limited effectiveness.	Offers the opportunity for nurses and midwives to provide creative and individualized care. To move away from the bureaucratic, impersonal, instrumental and technical type of care. Meets the nurses and midwives need to care for others. Allows nurses and midwives to be with the woman/patient/service user.	Only modest claims made for efficacy and risk. Lack of evidence.	Nurses and midwives holding an authoritative position in the hospital. Adept at negotiating professional boundaries.	As per the 2011 study above.



<b>Authors and Paper</b>	<b>Population</b>	<b>Study design</b>	<b>Benefits for women</b>	<b>Benefits for midwives</b>	<b>Constraining factors</b>	<b>Enabling factors</b>	<b>Limitations of study</b>
Jones, <i>et al</i> (2013)	Not discussed	Survey	Empowerment of women Less medicalization More individualized care Pain management Reduction in anxiety	Not discussed	Not discussed	Not discussed	Literature based, no empirical data.
Mitchell (2013)	Fourteen English speaking women in Bristol and Wiltshire regions, who had used at least one therapy in a past pregnancy or childbirth experience, and not be pregnant or within 6 weeks of giving birth.	Narrative interviews lasting 1.5 hours each.	To achieve a 'normal birth'. Avoidance of unnecessary medical intervention. To achieve an emotionally fulfilling experience. To achieve control. To promote confidence and manage fear.	Not discussed	Not discussed	Not discussed	English speakers only.

This part of the literature review concentrates on the attitudes held towards CAM and where possible homeopathy by maternity staff and those using maternity services. As described, these papers are reviewed using a number of thematic headings: attitudes held by NHS staff to homeopathy; attitudes towards the use of homeopathy by pregnant women; the provision of homeopathy within NHS settings; the use of homeopathy by women; the use of arnica by women; the perceived benefits of homeopathy; constraining influences on the availability of homeopathy in the NHS.

#### **3.4.1.1 Attitudes of NHS staff towards CAM/homeopathy**

The papers by Mitchell *et al* 2006, Williams *et al* 2007 emerged from a single research project and explored data obtained from a questionnaire sent to all UK maternity managers. The first of the reports by Mitchell, *et al* (2006) asked maternity managers about their attitudes to CAM and whether it was provided within their units. Even though the questionnaires were sent to heads of maternity units they were completed by all grades of midwife, many of who had an interest in CAM. Of the 221 questionnaires posted, 167 were returned, and of these 70% of respondents felt positively towards CAM, stating that they were '*convinced of the benefits*' and 94 percent expressed the view that CAM should be made available within the NHS.

#### **3.4.1.2 Attitudes towards the use of CAM/homeopathy by pregnant women**

In addition to the positive attitudes expressed by midwives and maternity managers, women also gave positive feedback to midwives when complementary therapies were offered (Williams *et al* 2007). Mitchell returned to this topic in 2013, this time in the form of a narrative study that explored the motivations and experiences of

women who had used CAM in pregnancy and childbirth (Mitchell 2013). In the Mitchell study (2013), 14 English speaking women, over the age of 18 and living in the Bristol and Wiltshire region were interviewed at length. Each woman interviewed had used a minimum of one CAM during a past pregnancy/childbirth experience, and at the time of the research were neither pregnant nor within six weeks of having given birth. The study revealed that the majority of women who used CAM did so as part of their aim to achieve a '*normal*' birth and to avoid any unnecessary medical intervention. One of the women stated:

*'All of it (CAM) was motivated by my desire to have a normal birth and to have myself emotionally and physically prepared as possible. I know how easy it is not to happen and I didn't want to set myself up as being horribly disappointed. I was investing a lot into how I wanted my labour to be'* (Mitchell 2013, p.101).

The interviews revealed that some of the respondents believed childbirth to be an inherently risky enterprise. Women described themselves as fearful and told the researcher that they engaged with complementary therapies as a part of their overall pregnancy and childbirth strategy. One participant said how she:

*'had always been frightened about giving birth especially what you see on the TV and how it's a scary thing'* (Mitchell 2013, p.101).

To manage her fear she started to use yoga believing that the class:

*'was very much about pregnancy being a natural experience, not something to be frightened about and how it can be over medicalised. It took me from being frightened about childbirth to thinking of it in a completely different way'* (Mitchell 2013, p.101).

The researchers noted that women were drawn to CAM because its philosophy was seen to be both woman and baby centred. CAM philosophy was identified as recognising both the spiritual nature of birth and the significance of birth in women's

lives'. In particular, homeopathy was used by three of the participants to help them manage the emotional elements of their labour. Mitchell points out how maternity services were not seen as meeting the needs of women, and called for collaborative working partnerships between midwives, women and CAM practitioners. CAM was seen as being closely linked to a type of '*normal childbirth*' that was in direct contrast to the medical approach seen to be offered by the medical profession.

#### **3.4.1.3 Provision of homeopathy within NHS settings**

It is difficult to determine exactly how widespread the provision of homeopathy is in the NHS. One of the reasons for this is that, having been designed to answer a range of alternate questions, not all the articles specify where, to whom, and how homeopathy is provided. A further reason is the difficulties created when attempting to compare the results of studies when the authors have each adopted a different definition of CAM. Williams and Mitchell (2007) was the only national study, and then it was only designed to determine the views of midwifery managers, and not midwives or service users. The Mitchell et al (2006) and Williams et al (2007) study revealed that 43% of the units that responded offered CAM to staff, 34% to mothers, and 23% to babies. They found the most widely offered therapies were massage<sup>20</sup> (54%), aromatherapy<sup>21</sup> (46%), reflexology<sup>22</sup> (33%), and acupuncture<sup>23</sup> (12%). Other, albeit less frequently offered, therapies included homeopathy, shiatsu<sup>24</sup>,

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<sup>20</sup> Massage is a "hands on" treatment in which a therapist manipulates muscles and other soft tissues of the body to improve health and well being.

<sup>21</sup> Aromatherapy is the use of essential oils from plants for healing. These oils are usually inhaled or massaged into the skin.

<sup>22</sup> Reflexology is a 'hands on' treatment that uses gentle hand and finger pressure on specific 'reflex points' which are believed to link to specific organs in the body.

<sup>23</sup> Acupuncture is the application of heat, pressure or needles to specific points in the body. It aims to encourage the free flow of Qi and restore balance to the individual.

<sup>24</sup> Shiatsu, widely used in Traditional Chinese Medicine, uses hand and finger pressure to specific points on the body to enhance the flow of qi through the meridians of the body.

reiki<sup>25</sup>, herbal medicine<sup>26</sup>, alexander technique<sup>27</sup> and osteopathy<sup>28</sup>. Homeopathy was provided to 2% of staff and 7% of women in maternity units. Midwives, sometimes in combination with independent practitioners, provided the majority of CAM, mostly on an informal basis. There had been a significant drop in CAM services provided by the NHS in the early 21st century, and this was in line with the increased bureaucracy raised in chapter two. The participants in the Cant et al (2011) study found their CAM services susceptible to closure owing to financial pressures and the rise in prominence of clinical governance. A respondent described how, after ten years of offering a CAM service, she received a letter advising her that because the hospital had a £60 million deficit her services were no longer needed. Similarly, the nurses and midwives had seen the impact of increased managerialism on their practice in greater regulation. Cant et al (2012, p.137) found this was a process that participants felt was '*over-bureaucratic, time-consuming and frustrating*'. This was all the more so in their perception of a lack of an evidence base for CAM belief and their belief that their institutions were unsupportive. This eventually led to some nurses and midwives abandoning their CAM practice. One of the midwives described how she became disappointed and disillusioned with her hospital, especially as she had paid for her own training. One of the midwives left the NHS after her CAM service was closed saying that she had been informed that (Cant et al 2012, p.137):

*'we are not sure about litigation and all this sort of thing. So we don't mind you using it, but you can't do it while you're working as a midwife, you can only do it when you're off duty – so I just retired from the NHS'.*

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<sup>25</sup> Reiki is a Japanese technique for alleviating stress and promoting relaxation by the laying on of hands.

<sup>26</sup> Herbal medicine is the use of therapeutic plants to treat illness.

<sup>27</sup> The Alexander technique teaches improved posture and movement which in turn is believed to help correct and prevent problems caused by unhelpful habits.

<sup>28</sup> Osteopathy aims to diagnose and treat a wide range of medical conditions by the use of touch, physical manipulation, stretching and massage to increase the mobility of joints, relieve muscle tension, enhance blood and nerve supply to tissues and help the body health itself.

The authors continue by describing how some nurses decided to leave the NHS in favour of their CAM practice. They explained how one particular nurse, after her attempts to develop policy had been thwarted, said:

*'[it is] ...a long and a very sad story, and ultimately it led me to leaving the NHS.... I put together very small working groups because you have to have things to support the policy and over four years we re-wrote, re-wrote, re-wrote, re-wrote, re-wrote, and eventually we got a policy...we went to the Medical Staff Committee, we went to parent and child groups...it went to the legal department...it got the whole way, it had everybody's approval, it had been to the executive, it had been to the executive board and they had agreed....the last hurdle was the clinical negligence group...and I wasn't allowed to attend the meeting... Oh it took me four years. Four years and then they threw it...I was crossing every 't' and dotting every 'i' and still fell flat on my face....'* (Cant et al 2012, p.137).

#### **3.4.1.4 Use of homeopathy by women**

A number of papers discuss the use of homeopathy by women (Mitchell & Williams 2006, Cant et al 2012, Bishop et al 2011, Carter & Aston 2012). The Avon Longitudinal Study was the largest and most comprehensive undertaken, and was designed to explore the '*determinants of development, health and disease throughout childhood and beyond*' within the Avon region (Bishop, et al 2011, p.304). The researchers collected data from four postal self-completion questionnaires conducted with pregnant women at 8, 12, 18 and 32 weeks gestation. Amongst the questions women were asked their use of any treatments, pills, medicines, ointments, homeopathic or herbal medicines, supplements, drinks or herbal teas. Data was available from 14,115 women making it the largest survey of its type in the UK. Their research revealed that over a quarter of women (26.7%) had used a CAM at least once during their pregnancy, and this use rose from 6% in the first trimester, up to 12.4% in the second trimester, reaching 26.3% in the third. The most commonly used type of CAM involved drinking herbal teas (17.7%), closely followed by homeopathic medicines (14.4%) and herbal medicine (5.8%). Chamomile tea was the most popular CAM, whilst was the most popular

homeopathic remedy was arnica (3.1%). Other CAMs used included osteopathy, acupuncture/acupressure, Chinese herbal medicine, chiropractic, aromatherapy, cranial sacral therapy, hypnosis, non-specific massage and reflexology. Together these made up less than 1% of CAM use amongst the participants. The study was able to associate the use of CAM with particular socio-demographic characteristics amongst the population. They found that older mothers were more likely to use CAM than younger, more likely to be working, more likely to be non-white, and more likely to be educated to degree level. In addition women who used CAMs were more likely to be married, own their own homes, and belong to social class I (higher professional and managerial occupations). The use of four points of data collection was useful in ensuring that the information given was within the recent memory of the participant. There is also the difficulty of ensuring that people understand what a CAM is and that they all report in a similar way. The authors chose to obtain large-scale quantitative data about the use of CAMs rather than any qualitative information about the experience of those using CAMs. The authors noted the difficulties of comparing this study to others as the findings are affected by different inclusion/exclusion criteria, the timing of data collection, the country where the research is being conducted, the number of women surveyed and the different selection criteria for recruitment to the study or means of categorising and identifying CAM treatments or products. Notwithstanding this concern, the data shows a substantial number of mothers in Avon using one or more CAMs. The study by Carter and Aston (2012) (described in 3.4.1.4) showed a higher percentage of women using arnica than the Avon study, however Carter and Aston's (2012) small-scale study was conducted in inner London, where owing to the demographics of the population the use may be different to other areas. This study was also designed specifically to enquire about the use of arnica, and therefore women may have been more highly motivated to report its use.

#### **3.4.1.5 Use of arnica by women**

As mentioned above, Carter and Aston (2012), two midwives, carried out a small-scale survey designed to explore the use of homeopathic arnica amongst childbearing women. This was a much smaller study than the Avon Study. Three hundred and seventy three women agreed to participate in answering a questionnaire, and of these 228 were completed and returned. Whilst the Avon Study reported 14.4% of women using homeopathy with 3.1% using arnica, this study found the figure using arnica to be 12%. Importantly however, they found that not all women were making appropriate use of the remedy with 81% judged to have '*possibly*' or '*probably not*' taken it correctly. Of the women surveyed 59% would have preferred information being made available about its use. The researchers suggested that maternity services need to make information about the use of homeopathic remedies to childbearing women who wish to self-prescribe.

#### **3.4.1.6 The perceived benefits of homeopathy**

Generally, CAM was seen as making a positive contribution to care in pregnancy and childbirth. The first paper by Mitchell & Williams (2006) found that CAM was seen to improve consumer satisfaction, improve the quality of care offered, promote normal childbirth and reduce medical intervention. Williams & Mitchell's (2007) second paper extended this discussion. They described how, for women, the benefits included '*choice*', '*personal satisfaction with the birth experience*', '*control*' and '*empowerment*'. The use of complementary therapies was seen to improve both the physical and mental wellbeing of mothers and lessened the number of visits and inpatient stays (Cant et al 2012). CAM was able to offer potential



solutions where effectiveness gaps were evident, and offered an alternative to technology driven practice.

An additional benefit to midwives and the Trusts, was in the reduced sickness levels experienced where CAM was made available as a service to midwives, and this was connected to a sense of being valued when CAM was offered (Cant et al 2012).

#### **3.4.1.7 Constraining influences**

The study by Williams and Mitchell (2007), noted a number of barriers to the use of CAM. The explanations provided for not implementing complementary therapies were diverse. Equity of provision was one of particular note; it was considered to be unethical if it could not be made available to everyone over a continuous period. A respondent stated: *'we have midwives trained in acupuncture, reflexology and Indian head massage but because we cannot provide 24 hours service our trust does not offer anything'* (Williams and Mitchell 2007, p. 132). Additionally, complementary therapies were not seen as a priority and as a result funding for training or materials was limited. The amount of organisational bureaucracy was also seen to limit to the provision of CAM. The midwives in the study stated how they felt frustrated owing to the amount of *'bureaucracy and lack of consensus'*, believing that *'so much depends on knowledge, power and the beliefs of those who hold the purse strings'*.

A lack of support was also evident in the participant's narratives. They believed there was a lack of support from both the medical profession and other midwives.

They described how they felt the '*medical profession [was] very unsupportive*' and the '*obstetrician in the unit generally sceptical and blocking progress, also some midwives don't see it as a priority*' (Williams and Mitchell, p.132).

Study participants felt that there was a poor understanding of the benefits that CAM could provide. This was exacerbated by a lack of RCT evidence, lack of regulation and questions about the competence of practitioners, and this was seen as exerting a negative effect on the provision of complementary therapies. NICE was seen as a problem by midwives, especially when it appeared to take a dismissive approach to complementary therapies. Despite these difficulties, the researchers found evidence that midwives, in many places, had been able to offer access to complementary therapies to women (Williams and Mitchell, 2007).

A study published in 2011, by Cant *et al* (2011) examined the role of CAM in the professionalisation of nurses and midwives. In doing so, they explored the use of CAM in NHS hospitals in 2008. The authors note how in the late 1980s/early 1990s nurses and midwives were engaged in a reconfiguration of their occupational status into '*autonomous, professional, "knowledgeable doers"*' (UKCC 1987). Witz (1994) felt that as part of this reconfiguration there was '*... an increasing emphasis on a patient centred, care driven model of nurse practice, underpinned by a holistic model of health and elaborated by means of a discursive reworking of the centrality of caring activity...*' (1994, p.24). The UKCC in their 1992 Scope of Professional Practice document described practitioners who had '*the competency and authority to make informed judgments rather than simply executing externally managed, formulaic, technical procedures*'. This allowed nurses and midwives to make their own judgments' about their personal competence. However despite this they found,

just as Mitchell and Williams (2007) had, that the policies and bureaucracies employed within the NHS, and what they describe as the mainstream marginality of CAM exerted a negative impact on the ability of practitioners to achieve autonomous practice and formal occupational rewards (Freidson 1994, Saks 1994). Notwithstanding this, the authors noted how practitioners continued in their efforts to offer CAM services.

A further paper by Cant, *et al* in 2012, (p.135) extended this study of the '*rise and fall of complementary medicine in NHS hospitals in England*'. During the first phase a group of midwives and nurses who had used CAM in the NHS were interviewed. The researchers asked participants about the history of their practice, details about the therapies they offered, how they were trained, how the service was paid for, whether colleagues were supportive, their views on those factors that enabled or constrained the provision of CAM, and their views on its impact and value. Telephone interviews were carried out with 18 current and former hospital based nurses and midwife CAM practitioners. They noted the difficulty, similar to my own, of locating midwife and nurse CAM practitioners owing to the fact that the NMC do not record non-statutory qualifications.

It was found that these midwives and nurses had been successful in introducing CAM within NHS hospital settings in the 1980's and 1990's. However, this use had largely declined apart from in some very specific practice settings. The authors reported that one of these exceptions could be found in midwife led units supporting normal birth. The therapies that had been successfully integrated included aromatherapy, reflexology, massage and acupuncture. They said that although several of the respondents had reported an interest in homeopathy, they had not

tried to develop its use within their own practice setting. It was generally felt that the provision of CAM was mostly ad hoc, with motivated individuals championing their development. One of the respondents had stated of the nurses that provided CAM that:

*'these are very unusual nurses. They are nurses that are going to get ahead anyway. There is something about them...they are natural leaders, they take initiative, they are not afraid to take risks'* (Cant et al, 2012 p.136).

Cant et al (2012) found that midwives and nurses often remained unsure about whether or not they could practice CAM, or whether they would be insured by their Trusts should they be subject to litigation. Similarly, just as Mitchell and Williams (2007) had, the participants in this study had also found that CAM was of very low priority. This meant that whilst they may have been given the space for delivering the service, they still had to maintain their normal workload and were not financially supported. This left them either having to supply and pay for the services themselves or ask for donations.

In 2013, Jones et al (2013), designed and conducted a study to examine the drivers for CAM integration into midwifery practice. The study was literature based and found consumerism to be a major factor in the development of CAM. Women, it stated, wanted a '*less medicalised and more empowered birth experience*' (Jones et al, 2013, p.2). The authors uncovered the existence of a number of gaps in the literature surrounding women as consumers in this area. Particularly, they argue there had been no differentiation in the literature between consumer interest and desire, and consequently everything had been classed as a '*demand*' for CAM. Similarly, the way this demand was articulated between midwives and women was unclear. They called for further research to be conducted in fully understanding

consumer demand, and that women should be given the chance to provide feedback.

#### **3.4.1.8 Factors identified as promoting the integration of CAM into maternity care**

The final theme covered the factors that were considered to promote the integration of CAM's into midwifery practice. Importantly, just as the influence of colleagues was a negative factor, many midwives found support within the ranks of colleagues or managers. Demand from consumers and midwives were also seen to have a significant impact on the availability of CAM. Midwives were reported as saying '*consumer pressure is fundamental to the delivery of our service*' (Cant, *et al* 2012 p.133), although this must be considered in the light of their statement that both '*interest*' and '*desire*' about CAM has been conflated as demand. Notwithstanding this, there is a generally a recognition of the potential contribution that CAM can make in the promotion of normal birth.

In practice, respondents reported how just being motivated was, on its own, insufficient to develop CAM services (Mitchell *et al* 2006, Cant *et al* 2012). It was also necessary to hold a senior position in the hierarchy and be very astute at negotiating professional boundaries (Cant *et al* 2012). Thus, it was the combination of being highly motivated and having the authority to affect change that enabled the successful introduction of CAM services. In addition, it helped when midwives and nurses chose to use a very clear strategy when trying to introduce therapies into practice. One of these strategies discussed, included selecting those therapies that met a specific need, for instance, where there was either very little that biomedicine could offer because of a lack of treatment options, or where there was

a lack of interest on the part of nursing, midwifery or medical staff (Cant *et al* 2011, Cant *et al* 2012). The midwives and nurses spoke about how the therapies were introduced in low-key ways or with the use of a biomedical model. One midwife spoke about how she '*played safe*' by only asking to use six aromatherapy oils, whilst another midwife reports how she '*presented it pretty much hand in hand with sort of conventional Western medicine*' (Cant *et al* 2012, p.137). Midwives were aware of a lack of evidence on efficacy and risk in the therapies. However, this deference to an EBM hierarchy based on efficacy is indicative of how EBM/EBP has been embraced by the midwifery profession amongst other medical professionals. In fact, the nurses and midwives in the study still held a '*strong practical and epistemological commitment to biomedicine*', and in midwifery the use of CAM's was restricted to '*normal*' pregnancies only (Cant *et al* 2012, p.137). This relationship with biomedicine was at times a difficult one. Midwives and nurses were left trying to negotiate a path where there were '*two incompatible positions*'. On the one hand the practitioners had to demonstrate the safety (or ineffectual) nature of the CAM, yet also had to prove that it was '*sufficiently effective*' (therefore risky).

### **3.4.2 Summary of the key points**

In summary the studies show that between 27.5% and 34% of units offered CAM services to childbearing women. It is, however, not always possible to break these figures down further to obtain more specific information about where, to whom, and how homeopathy is provided. The studies were designed to answer a range of different questions and the authors have also used different definitions of CAM. Of the studies undertaken, only the Williams and Mitchell (2007) took the form of a national study, and then it was only designed to determine the views of midwifery managers, and not midwives or service users. The remaining studies were

regional, and therefore, the results may only apply to the local area and not reflected elsewhere. Where they were available, the figures for the use of homeopathy were different in each of the studies; however they demonstrated that a significant minority of women made use of homeopathic remedies. The Avon study was the largest study that researched the use of CAM by women, and this showed 14.4% of women using homeopathy with three percent using arnica. The study by Carter (2012) showed a higher percentage of women using arnica, however this small-scale study was conducted in inner London, where owing to the demographics of the population the use may be different to other areas. This study was also designed specifically to enquire about the use of arnica, and therefore women may have been more highly motivated to report its use.

Significant themes do emerge from the literature, particularly in two areas. The first area concerns the benefits for women and midwives, whilst the second provides information on the factors that enable and constrain the implementation of CAM. The benefits for women surround the promotion of normal childbirth with a reduction in the amount of medicalisation and intervention required. The use of CAM was seen as offering women choice, empowerment and control. In addition CAM was able to offer a range of alternative treatments where conventional treatment gaps had been identified. The benefits for midwives lay in the ability of CAM in promoting normal childbirth, improving the quality of the care offered and providing a sense of job satisfaction. Midwives using CAM also noted how it enabled them to '*be with women*' and provide holistic care.

There was consensus amongst the respondents in the various studies about those factors that constrained or enabled the use of CAM in hospital settings.

Constraining factors included a lack of funding or training, the perception that CAM was of a low priority, concerns about practitioner competence, the lack of autonomy in midwives, risk management and clinical governance, lack of suitable evidence, a fear of litigation, unsupportive medics and midwives and the incompatibility of the positions adopted by conventional medicine and CAM. The enabling factors tend to centre on consumer demand and motivated and committed individuals who have sufficient authority to affect change.

The next section of this chapter examines clinical studies of homeopathy in maternity care.

### **3.4.3 Trials of homeopathy in maternity care**

The previous chapter (2.11.1) discussed the systematic reviews of homeopathy in relation to the debates around '*evidence*'. A crucial difference between the systematic reviews and meta-analyses discussed in chapter two and those presented in this chapter is that the trials included in the systematic reviews in chapter two included many clinical areas. In this section I review the studies designed to test the use of homeopathy in maternity care. The studies in this group are made up of systematic reviews, randomised controlled trials, non-randomised controlled trials, case studies, and qualitative studies. I include them here, whilst recognising the debates surrounding the potential limitations imposed by the methods used to generate the data. These trials appear in Table 4 (Literature on homeopathy in pregnancy, childbirth and postpartum – Clinical Studies), and further detail is provided in the table overleaf (Table 6).



Table 6: Clinical Studies					
Author, year, country	Methods	Patients	Treatments	Results	Comments
Systematic Reviews					
Boltman, H. (2005)  <i>A systematic review on maternal and neonatal outcomes of ingested herbal and homeopathic remedies used during pregnancy, birth and breastfeeding.</i>  South Africa	Systematic Review	8 studies identified:	Oral evening primrose oil: its effect on length of pregnancy and selected intrapartum outcomes on low risk nulliparous women Use of castor oil at term for induction of labour. Postpartum use of arnica (potency finding study) Effect of caulophyllum on length of labour. Effect of Isihlambezo on pregnancy outcome. Effect of fish oil on pregnancy duration. Raspberry leaf in pregnancy: safety and efficacy in labour. Ginger treatment of hyperemesis gravidarum.	The study could not provide substantial evidence on the majority of outcomes.	Study confuses herbal, homeopathic and supplements. Studies too dissimilar.

Author, year	Methods	Patients	Treatments	Results	Comments
Smith, C.A. (2008)  <i>Cochrane review - Homeopathy for the Induction of Labour</i>  UK	Systematic Review	Review of 2 trials (Beer and Heiliger 1999, Dorfman, Lasserre and Tatau 1987)		Insufficient evidence to show the effect of homeopathy as a method of induction.	The studies in the systematic review were not of sufficiently high quality. Insufficient information on randomisation.
Quantitative studies					
Atmadjian, Jeanvoine and Hariveau (1998)  <i>Analyse de l'étude d'arnica dans l'accouchement</i>  France	Parallel No assignment Double blinded 7 day follow up 1 centre	<b>Condition:</b> childbirth <b>Inclusion:</b> missing <b>Exclusion:</b> missing <b>Numbers included/ analysed (percent attrition):</b> 30/30 (0percent) <b>Demographics:</b> Female no age given	<b>Homeopathy:</b> Arnica C7 <b>Dosage:</b> missing <b>Control:</b> Placebo	<b>Clinical outcomes:</b> Minutes of labour 47.8 vs. 49.53	No inclusion or exclusion criteria listed. No ages of women available. Small sample and no calculation of sample size. Dosage and repetition missing from report.
Beer and Heiliger, (1999)  <i>Double blind trial of Caulophyllum D4 for induction of labour after premature rupture of membranes at term.</i>  Germany	Prospective Randomised Double blinded	<b>Condition:</b> childbirth <b>Inclusion:</b> 38-42 gestation Premature amniotic rupture Cervical dilation $\leq$ 3cm. No regular contractions <b>Numbers included:</b> 40 <b>Demographics:</b> female -no age given	<b>Homeopathy:</b> Caulophyllum D4 <b>Dosage:</b> 1 tablet an hour for 7 hours <b>Control:</b> Placebo	<b>Clinical outcomes:</b> Time between application of the first tablet and start of regular uterine contractions. No significant outcomes	The study is small and requires a follow up trial. Insufficient information on randomisation. No calculation of sample size included.

Author, year	Methods	Patients	Treatments	Results	Comments
Berrebi, Parant and Ferval <i>et al</i> (2001)  <i>Treatment of pain due to unwanted lactation with a homeopathic preparation given in the immediate post-partum period.</i> France	Parallel Randomised Double blinded No assignment	<b>Condition:</b> Pain due to unwanted lactation <b>Numbers included/analysed (percent attrition):</b> 71 <b>Inclusion:</b> Women who did not want to or could not breastfeed. <b>Exclusion:</b> Missing <b>Demographics:</b> female-no age given	<b>Homeopathy:</b> Apis Mellifica 9CH and Bryonia 9CH combination <b>Dosage:</b> 5 granules morning and evening for 10 days. <b>Additional treatment:</b> Naproxen 1 tablet morning and evening 5 days Fluid restriction 500ml per day without food.	<b>Clinical outcomes:</b> Breast pain measured twice daily for 4 days by the patient. A significant improvement of lactation pain, breast tension and spontaneous milk flow in the homeopathic arm	No information about the allocation of groups. Not all participants accounted for at the conclusion of trial.
Dorfman, Lasserre and Tetau (1987)  <i>Homoeopathic preparation for labour: two fold experiment comparing a less widely known therapy with a placebo.</i> France	Parallel Double blinded Randomised 1 centre -	<b>Condition:</b> childbirth <b>Inclusion:</b> all women who were not explicitly excluded. Treatment time of 15 days. <b>Exclusion:</b> Parturients who had obstetrical complications i.e. Hypertension, diabetes, or previous caesarean because of abnormal foetal problem or virus. <b>Numbers included/analysed (percent attrition):</b> 93	<b>Homeopathy:</b> Arnica/caulophyllum/cimicifuga /actea-racemosa/pulsatilla/gelsemium combination 5CH. Dosage: 3 pills morning and evening starting from the beginning of the 9 <sup>th</sup> month. At beginning of contractions dose repeated up to every 15 minutes for up to 2 hours.	<b>Clinical outcomes:</b> Average duration of labour 5.1 hours for the homeopathy group/8.5 hours for placebo group. Numbers of dystocias (abnormally slow progress due to ineffective uterine contractions) Observed dystocias 11.3 for homeopathy group and 40 percent for placebo group.	The information provided is not sufficiently detailed on randomisation and blinding. Results not detailed precisely enough. Attrition numbers not available.
Hofmeyer, Piccioni and Blauhof (1990)  <i>Postpartum homeopathic arnica montana: a potency finding pilot study.</i> South Africa	Parallel Pilot study Randomised Double blinded	<b>Condition:</b> childbirth <b>Inclusion:</b> Women who had experienced tears or episiotomy during childbirth <b>Numbers included/analysed (percent attrition):</b> 161 <b>Demographics:</b> Female	<b>Homeopathy:</b> Arnica D6 against arnica D20 <b>Control:</b> Placebo	<b>Clinical outcomes:</b> Subjective scores of patients measuring perineal pain, chest pain, general mood, analgesic use. Subjective assessment of the effectiveness and objective findings of wound haematoma, oedema and inflammation.	Information provided not sufficiently clear about randomisation. Trial of one potency against another. Pilot study.

Author, year	Methods	Patients	Treatments	Results	Comments
<p>Oberbaum, M. <i>et al</i> (2005)</p> <p><i>The effect of the homeopathic remedies and bellis on mild post-partum bleeding</i></p> <p>Israel</p>	<p>Clinical trial Double blinded Randomised 1 centre -</p>	<p><b>Condition:</b> Mild postpartum bleeding after childbirth <b>Inclusion:</b> weeks 37-43 pregnancy 1-4 previous deliveries scheduled for spontaneous vaginal delivery of single baby <b>Exclusion:</b> Previous caesarean, Antepartum or postpartum haemorrhage in previous pregnancies Coagulopathies. <b>Numbers included/analysed (percent attrition):</b> 45 (5 patients required intervention and 2 patients were non-compliant) <b>Demographics:</b> female 20-35 weeks</p>	<p><b>Homeopathy:</b> Arnica and bellis 10<sup>-6</sup> or 10<sup>-60</sup> or placebo.</p>	<p><b>Clinical outcomes:</b> Haemoglobin levels at 48 and 72 h postpartum. Mean differences in Hb levels at 72 h postpartum were -0.29 (95 CI – 1.09; 0.52) in the treatment group and -1.18 (95 percent CI – 1.82; -0.54) in the placebo group. (p&lt;0.05)</p>	<p>Only pilot data presented. Small study.</p>
<p>Ventoskovskiy, B.M., <i>et al</i> (1990)</p> <p><i>Homeopathy as a practical alternative to traditional obstetric methods.</i></p> <p>Russia</p>	<p>Non-randomised controlled trial.</p>	<p><b>Condition:</b> disturbances of uterine contractile function. Inclusion: Mothers at high risk of uterine contractile function disturbances. <b>Numbers included/analysed:</b> 102 received homeopathy only; 104 received oestrogenic hormones. Compared with group of 151 pregnant women at high risk of uterine inertia and post partum haemorrhage who did not receive prophylactic treatment. <b>Excluded:</b> pregnant women with foeto-placental insufficiency,</p>	<p><b>Homeopathic arm:</b> Complex prescription of: pulsatilla 1M, secale 50c, caulophyllum 50c, actea race. 200c, arnica 1M. <b>Dosage:</b> drugs alternated every 30 minutes (6 granules) for 10 days.</p> <p><b>Conventional arm:</b> 300-500 units of synestrol per kg of body mass; 1.0 of galaxorbin and glutamic acid tds; thiamine and pyridoxine 1ml of 5 percent solution; 10ml of 10 percent solution of calcium chloride;</p>	<p><b>Clinical outcomes:</b> Prophylactic use of homeopathy for pregnant women at high risk of uterine inertia and post partum haemorrhage is at least as effective as traditional prophylaxis.</p>	<p>Prophylactic treatment. No information on randomisation, no masking. Demographic information not clear.</p>

		foeto-development anomalies, multiple pregnancy, hydramnios, placenta praevia, preeclampsia, critical extragenital pathology. Women over 40 weeks gestation and those who received prophylaxis treatment within 5 days of delivery.	20ml of linetol and 100mg of glutathione twice daily. <b>Dosage:</b> 10 days.  <b>Control group:</b> 151 women at high risk – no prophylactic treatment.		
Case Controlled Study					
Author, year	Methods	Patients	Treatments	Results	Comments
Eid, Filisi and Sideri (1993)  <i>Applicability of homeopathic caulophyllum thalictroides during labour</i>	Case control Non random No masking Follow up – till delivery 1 centre – Italy	<b>Condition:</b> childbirth <b>Inclusion:</b> primiparis; spontaneous labour at term; valid painful contractions $\geq 2/10$ min lasting $\geq 45$ seconds; 3cm cervical dilation; effacement; medical or surgical treatment after cervical dilatation <b>Exclusion:</b> diabetes; hypertension; previous uterine surgery; treatment with tocolytics $\leq 4$ weeks prior to admission; premature amniotic rupture; medical or surgical treatment during cervical dilatation <b>Numbers included/analysed (percent attrition):</b> 56/51 (8.93 percent) <b>Demographics:</b> female 23-37 years	<b>Homeopathy:</b> Caulophyllum C7 <b>Dosage:</b> 5 granules/h $\geq 4$ hours <b>Control:</b> No treatment	<b>Clinical outcomes:</b> Cervical dilatation (min) 227 vs 314 ( $p < 0.05$ )	No randomisation, no masking, no controls.

Author, year	Methods	Patients	Treatments	Results	Comments
Case Studies					
Hutchinson (2005)  <i>Homeopathic simillimum treatment on haemorrhoids during pregnancy.</i>  South Africa	Case Study	<b>Condition:</b> Haemorrhoids in pregnancy. <b>Inclusion:</b> 12-35 weeks gestation. <b>Exclusion:</b> Not stated <b>Numbers analysed:</b> 12 <b>Demographics:</b> female – aged 18-35	<b>Homeopathy:</b> Simillimum treatment. (remedies include aesculus, aloe, collinsonia, hamamelis, kali carb, mercurius, muriatic acid, nat mur, nit ac, petroleum, pulsatilla, rathania, sepia – various potencies from 5c-200c)	<b>Outcomes:</b> 83 percent showed some improvement of haemorrhoids (subjective)	Small study. Absence of control group. No exclusion criteria. No base line of haemorrhoid severity conducted prior to commencement of study.
Kruger (2007)  <i>The effect of homeopathic simillimum treatment on pyrosis during pregnancy.</i>  South Africa	Case Study	<b>Condition:</b> Pyrosis during pregnancy. <b>Inclusion:</b> 12-32 weeks gestation. Aged 18-35, normal uncomplicated pregnancy. <b>Exclusion:</b> Heartburn before pregnancy, hiatus hernia, peptic ulcer, serious health complications before pregnancy, delivery of baby before completion of the study. <b>Numbers analysed:</b> 12 <b>Demographics:</b> Female – aged 18-35	<b>Homeopathy:</b> Simillimum treatment. (remedies include arsenicum (x2), calc carb, capsicum, lachesis, lycopodium, nat mur, nux vomica, phosphorus, sepia, pulsatilla, (x2)	<b>Outcomes:</b> 100 percent of participants experienced a decrease in the self reported severity of symptoms.	Small study. Absence of control group. Questions difficult for participants to answer therefore subjective evaluation of symptoms by participants.

Author, year	Methods	Patients	Treatments	Results	Reason for exclusion
Qualitative Studies					
Steen and Calvert (2007)  <i>Homeopathic remedies for self-administration during childbirth</i>  UK	Semi structured questionnaire and interviews.	<b>Condition:</b> Childbirth and during early postnatal period. <b>Inclusion:</b> Expected date of delivery within study period. <b>Exclusion:</b> Using other complementary therapies. <b>Demographics:</b> Female aged 16-40		<b>Results:</b> Women reported wide use of the kit, and the study recorded some beneficial value for women and their birth partners.	Exploratory study, small sample size (n=19). No clear inclusion/exclusion criteria.
Paruk (2006 )  <i>A survey to determine the perceptions that exist among pregnant adults towards the use of homeopathy during pregnancy.</i>  South Africa	Survey	<b>Inclusion criteria:</b> Pregnant women in the Durban area attending private ante-natal classes. <b>Exclusion criteria:</b> not stated Numbers analysed: 130 questionnaires distributed/60 correctly completed/23 discarded as incorrectly completed/47 not returned. Demographics: females aged 18-34		<b>Results:</b> Participants expressed confusion with traditional healing methods. Participants had some knowledge of homeopathy, although the study recommends further education.	Participants were not representative of the population. Of the questionnaires returned 18 percent were considered non-viable. The researcher identified significant shortcomings in the design of the research in meeting the study objectives. No ethical permission granted.

Author, year	Methods	Patients	Treatments	Results	Reason for exclusion
<p>Hochstrasser, B., (1999)</p> <p><i>Quality of Life of Pregnant Women depending on a homeopathic or mainstream medical type of care and on the course of the pregnancy.</i></p> <p>Germany</p>	Questionnaire	<p><b>Condition:</b> Pregnancy</p> <p>Inclusion: pregnant women cared for by a physician specialising in homeopathy (n=120) and pregnant women cared for by mainstream gynaecologists (n=85).</p>	Quality of life assessed twice during pregnancy and once shortly after delivery.	<p><b>Results:</b> the two groups (homeopathic and mainstream) were found to be different populations.</p>	<p>This was not a test of homeopathy in pregnancy, childbirth and the postpartum period, but an assessment of the difference in perception of quality of life between those women choosing homeopathy or mainstream medical care.</p>

Table 6: Clinical studies of homeopathy in pregnancy, childbirth and postpartum.



The literature shows that clinical research has been conducted in homeopathy for pregnancy and childbirth conditions. However, relative to the popularity of homeopathy worldwide, the number of studies is small, and there has been no definition or consensus about the type of homeopathy tested. This means that where homeopathy has been tested, it has been on a range of pregnancy, childbirth and postpartum conditions, using a single or combination remedy, using a variety of non-standard potencies and dosages. Only one of the studies has been replicated (Eid et al 1993; 1994). This makes comparison extremely difficult. It is not possible therefore, to draw any definitive conclusion for the use of homeopathy for particular conditions of pregnancy and childbirth.

The induction of labour is the only condition in maternity care that has been consistently tested using homeopathy. This was the subject of a Cochrane review (Smith 2009), which reached the conclusion that homeopathy could not be recommended. Nonetheless, some clinical studies would appear to indicate that homeopathy might be effective for some conditions. Initially I chose to use the Critical Appraisal Skills Programme (CASP) criteria to appraise the literature, as it is a commonly used tool, and I wanted to identify the effect of the use of a standard tool on the outcomes. No studies met the CASP criteria largely on methodological or reporting grounds. I have included an example of the use of the CASP tool for one of the studies in Appendix 8 (p.342). It is possible, however, that studies were excluded that could yield important information if they were viewed in a more holistic light. This demonstrates the very real difficulty of attempting to measure a complex intervention, such as homeopathy, using the traditional building blocks of the EBM pyramid that places systematic reviews and meta-analyses at its apex. By evaluating only what EBM's proponents call the '*best available evidence*' there is a

very real possibility that the type of evidence generated by '*untrustworthy*' methods is left un-reviewed.

#### **3.4.3.1 Homeopathy during pregnancy**

The search revealed only three clinical studies of the use of homeopathy during pregnancy. Of these, one was a quality of life study (Hochstrasser 1999), whilst the two remaining trials examined homeopathic simillimum treatment for specific conditions experienced during pregnancy (Hutchinson 2006, Kruger 2007). The first, by Hochstrasser (1999) explored the quality of life of 120 pregnant women treated by doctors of homeopathy and compared this to 85 pregnant women cared for by conventional gynaecologists. They assessed the participants' quality of life twice during pregnancy, and once shortly after delivery. They discovered that the women who expressed a preference for homeopathic care judged their quality of life to be lower than those in the conventional group. However the researchers found that there were also differences in the criteria they used for medical decisions and their assessment of their personal situations. The researchers concluded that the study showed the importance of clinicians paying attention to the subjective world of pregnant woman, although there is no further explanation of what the researchers meant by this statement in the context of their research.

The remaining two studies by Hutchinson (2006) and Kruger (2007), both undertaken as part of the researchers pre-registration training as homeopaths, examined simillimum homeopathic treatment for specific conditions in pregnancy. Hutchinson's (2006) study, described as a quantitative descriptive study used a self-administered questionnaire to examine the treatment of pregnancy induced haemorrhoids. Participants were asked to report on their symptoms on a daily basis throughout the four-week period of the study. The results of the study demonstrated that 83% of women felt they had improved on homeopathic simillimum treatment

and found a significant decrease in the severity of their pain and protrusion of the haemorrhoids. They concluded that the use of homeopathy within a clinical setting was effective in relieving the pain of haemorrhoids in pregnant women, but called for further research in this area. Kruger (2007) conducted a very similar study to Hutchinson's, but instead chose to examine the effect of homeopathic *simillimum* treatment in pyrosis associated with pregnancy. This study of 12 pregnant women between 12-34 weeks of gestation used a range of remedies of varying potencies, asking participants to evaluate their symptoms daily for 4 weeks. The researcher also interviewed each participant three times over the study period. The data from the interviews was then used to write in-depth case studies. It was found that there was improvement in the severity of pyrosis in all participants, with 9 of the 12 participants also experiencing improvement in the frequency of the pyrosis. The researcher suggests that the use of homeopathic *simillimum* treatment for the treatment of pyrosis in pregnancy may be useful and should be evaluated further. In both studies the researchers also found that the participants concomitant symptoms were also seen to improve.

#### **3.4.3.2 Homeopathy as preparation for childbirth**

There were two trials using homeopathic remedies to prepare women for childbirth (Dorfman, Lasserre and Tetau 1987, Ventoskovskiy and Popov 1990). Dorfman *et al* (1987) conducted a randomised double blind placebo controlled trial of non-classical homeopathy. The study was designed to test the use of a combination remedy made up of *caulophyllum*, *arnica*, *actea racemosa*, *pulsatilla* and *gelsemium* in 5C potency taken twice a day throughout the ninth month of pregnancy. The researchers found that the duration of labour was reduced to 5.1 hours v 8.5 hours ( $p < 0.001$ ) in favour of the homeopathy group and the percentage of mothers

reporting dystocia was 11.3 percent vs. 40 percent ( $p < 0.01$ ) in favour of the homeopathy group.

Ventokovskiy and Popov (1990) carried out a clinical trial testing the efficacy of homeopathic prophylactic remedies for uterine inertia and post-partum haemorrhage. Included were 206 participants, 104 of which received only homeopathy (group a) and 102 only conventional medicines including oestrogenic hormones. (group b). In addition both groups were compared with a control group ( $n=151$ ) that did not receive any treatment pre-delivery, but who were still considered to be at high risk of uterine inertia and post-partum haemorrhage. (group c). The homeopathic remedies were used in combination (pulsatilla 1M, secale 50C, caulophyllum 50C, actea-racemosa 200C, arnica 1M), and participants were given one dose every 30 minutes of each remedy in alternation. The research team concluded that homeopathy could be used as an effective method for preparing for uterine contractile function in delivery and at the postnatal stage for women at high risk for complications.

#### **3.4.3.3 Studies of Labour**

There are a number of studies researching the use of caulophyllum in labour. Of these, the Cochrane Review discarded the studies by Coudert-Deguillaume (1981) and Arnal-Lassere (1986), as they were unable to locate a copy of the research. I also encountered the same difficulty and was not able to obtain copies. However, these studies were reviewed by Dean (2006) as part of a PhD thesis examining trials of homeopathy. The Coudert-Deguillame (Dean 2006) study is reported as a trial of caulophyllum C5 for the relief of pain, with caulophyllum being taken every fifteen minutes until relief or for two hours (whichever sooner). The trial design was

reported as being a parallel-randomised double blind trial in one maternity centre in France. The inclusion criteria were painful contractions of more than two hours without dilatation, or normal contractions with dilatation arrested at 40mm. There were no exclusion criteria reported. Thirty-four women were included in the trial with a mean age of 24.9 years, with no dropouts. The team reported a positive result in favour of homeopathy with 76.5% v 11.7% responding ( $p < 0.005$ ). False labour was stopped in 6 out of the 9 in the homeopathy group v 0 from 11 in the control group. Problems with difficult labour were alleviated in seven out of eight in the homeopathy group and two out of six in the control group.

Beer and Heiliger (1999) carried out a randomised, double blind trial in Germany of caulophyllum D4 for induction of labour after premature rupture of membranes at term. Women were recruited to the study at 36 weeks. Dosages of caulophyllum were repeated hourly for seven hours or until labour started. The outcomes measured were the time taken before the onset of regular uterine contractions, labour and delivery outcomes, and maternal and neonatal infections. The results were non-conclusive.

#### **3.4.3.4 Other studies of remedies prescribed before or at the onset of labour.**

Eid *et al* (1993) conducted a case controlled, randomised double blind trial, designed to assess the applicability and potential toxicity of caulophyllum in labour. The study was undertaken in two phases, the first phase was the prescribing of caulophyllum 7C sublingually to a group of 22 first time mothers, going into spontaneous labour at term. Women were excluded who had diabetes, hypertension, previous surgery, and tocolytics or had experienced a premature rupture of the amniotic membrane. Phase 2 of the study selected 17 patients from

the original 22 who had normal and spontaneous labour and parturition. No details are given on why the 17 patients were chosen to enter phase 2 of the study. This group was retrospectively compared with a random control group of 34 mothers who had gone into labour during the same period, using the same inclusion and exclusion criteria. The clinical outcome measured was the duration of labour, which was significantly shorter in the caulophylum group (227 minutes) when compared to the control group (314 minutes) ( $p < 0.05$ ). This is the only study that has been repeated, in this instance in 1994 and the researchers found similar results, this time the duration of labour for the caulophylum group was 210 minutes v 355 minutes for the control group. The results of this study were disseminated via conference proceedings (Eid *et al* 1994).

The Arnal-Lasserre (1996) study was also examined and reported on by Dean (2006). The study was described as a parallel-randomised double-blinded controlled trial that took place over a one-month period in a single French maternity centre. The inclusion criteria stated that participants had experienced a history of previous obstetric difficulties, serious illness in months one to eight, or the patient required a caesarean because of infection; or there was foetal-maternal disproportion. Ninety-three women were included in the study with no dropouts. The homeopathic regime was a combination remedy of *actea-racemosa*; *arnica*; *gelsemium* and *pulsatilla* in C5 potency. Participants were given 2 doses of 3 tablets that were increased at the start of contractions to 3 tablets every 15 minutes. The outcomes measured were the duration of labour, which was 5.1 hours in the homeopathy group v 8.48 hours in the control group ( $p < 0.001$ ); and dystocia, which was reported as 11.3% in the homeopathy group v 40% in the control group ( $p < 0.001$ ).

Steen and Calvert (2007) evaluated the use and impact of a self-administered kit of homeopathic remedies used at the end of pregnancy, childbirth and during a short period after birth. The study took place in South Leeds in the United Kingdom. Nineteen women between the ages of 16 and 40, and their partners, were provided with guidance about the remedies, and asked to note their reasons for remedy choice and their perceived response to the remedy. Ninety-five percent of the participants had a UK white ethnic background, 89 percent were in employment and 74 percent were having their first baby. Of the 19 interviews arranged, 18 women and their partners (where available) were interviewed about their views about using the 10 remedy homeopathic kit. The interviews took place in their own homes two to three weeks after the birth using a semi-structured interview technique with prompts where required. The data were crosschecked two to three weeks later for accuracy by the participants. The data generated were analysed using a thematic approach and five themes identified. The themes developed included '*how the remedies were used*', '*empowerment*', '*emotional needs*', '*Dads and birth partners*' and '*positive birth experience*' (Steen and Calvert 2007, p.361).

The researchers found that women used the remedies widely during and after the birth and found them to be helpful in relieving anxiety as well as to aid with tiredness and exhaustion. Participants were reported as using the remedies for the '*baby blues and weepiness*' (Steen and Calvert 2007, p.362), and they were also used to help healing. Generally the birth partners were positive about the remedies, although one was reported to be sceptical. On the other hand, the response from midwives and medical staff was mixed. Some staff were supportive, however others were described as being '*dismissive*' and '*negative*' about the mothers and

their partners use of the kits. Empowerment was a major theme that arose from the study. Women and their partners believed that the kit gave them focus and helped them to feel in control. It also helped the partners in that it gave them an effective role in the birth process. Overall the kits helped some women physically and emotionally throughout the later part of pregnancy, during childbirth and postnatally. The study was unable to draw any firm conclusions about whether the remedies helped women stay at home longer during labour. This study is the only qualitative study that has examined the impact on mothers and partners of the use of homeopathy during this period. The researchers believe the use of homeopathy to be congruent with the RCM campaign for normal birth (2005).

#### **3.4.3.5 Postpartum use of homeopathy**

There are three dissimilar documented trials using homeopathy during the postpartum period. The first of these examines the effect of arnica and bellis perennis on mild postpartum bleeding (Oberbaum *et al* 2005), the second, the use of homeopathy for the treatment of pain during unwanted lactation (Berrebi *et al* 2001), and the final study, Atmadjian *et al* (1998) on the use of arnica for postpartum pain.

Oberbaum *et al* (2005) conducted a double-blind placebo-controlled randomised clinical trial for arnica and bellis perennis on postpartum blood loss. Forty women were randomised to three groups; arnica 6C and bellis perennis 6C (n=14); arnica 30C and bellis perennis 30C (n=14) or double placebo. After 48 hours the arnica/placebo was discontinued and patients continued with bellis/placebo until cessation of lochia. The main outcome measure was haemoglobin levels measured at 48 and 72 hours postpartum. The results at 72 hours postpartum the mean



haemoglobin levels remained similar after treatment with homeopathic remedies (12.7 v 12.4) as compared to a decrease in haemoglobin levels in the placebo group (12.7 v 11.6). The authors suggest that arnica and bellis perennis may reduce postpartum blood loss when compared with placebo.

Atmadjian *et al* (1988) completed a double-blinded randomised controlled trial in a single centre in France, with a follow up period of seven days. It was designed to analyse the clinical effect of arnica for perineal pain after childbirth. There were 30 women included in the trial with no dropouts. The authors state that the results in favour of arnica were largely positive there was no statistically significant result, owing to the small sample size.

Berrebi *et al* (2001) tested a combination remedy (apis mellifica 9C and bryonia 9C), for the pain of unwanted lactation, on 71 patients in a double blind placebo controlled study. All the participants received the basic treatment of naproxen and fluid restriction. The patients on the homeopathy treatment arm experienced a significant improvement in lactation pain (Day two –  $p<0.01$  and Day four –  $p<0.01$ ) with a similar effect for breast tension and spontaneous milk flow (Day four –  $p<0.01$ ). No other differences were found and the authors recommend the integration of this homeopathic combination.

### **3.5 Homeopathy: a complex intervention**

The effect of adopting a hierarchy of evidence that places systematic reviews/meta-analyses at the top with expert opinion at the bottom can be seen when reviewing the research studies in this area (Craig *et al* 2013). A particular difficulty is that

RCT evidence is singled out for use in meta-analyses and systematic reviews, which effectively means that great deal of valid information may be disregarded about many health interventions (Craig *et al* 2013). Petticrew and Roberts (2002, p.529) consider that having only a single hierarchy has:

*'become increasingly unhelpful and at present certainly misrepresents the interplay between the question being asked and the type of research most suited to answering it'.*

A range of alternatives has been mooted, including Reilly's (1993) '*mosaic of evidence*', Petticrew and Robert's (2002) '*typology of evidence*' and Walach's (2006) '*circle of methods*'. Likewise, an integrated approach to researching complex interventions has been supported by the Medical Research Council (MRC) (Craig *et al* 2013). The guidance provided by the MRC (Craig *et al* 2013) states that whilst experimental designs are more desirable it recognises that they are not always viable. The MRC also believe that whilst it is essential to understand process this does not replace the evaluation of outcomes. Furthermore, the guidance notes that complex interventions may work best when personalised to local circumstances rather than being standardised. Finally the MRC state that reports of studies should be sufficiently detailed to allow the study to be replicated and for wider implementation to be made possible.

Petticrew and Roberts (2002), referring to Muir Gray (1996) recommend the use of what they called a '*typological triage*'. This approach places different research methods at the top of the hierarchy depending on the question being asked. They believe it to be a much more useful approach. The researcher can consider how best they can utilise the extensive assortment of evidence available to them. Similarly, Reilly (1993) perceived that different research problems required different approaches. He called his approach '*evidence mosaics*', stating that '*evidence*

*does not come from one type of research alone but from a mosaic of evidence derived from the use of different approaches and methods'* (Walach 2003, p.10).

However, whereas Reilly notes the importance of using a range of types or research, he does not provide details on the combinations of research that would be appropriate. Walach (2003) provides this detail, suggesting that when compiling evidence, the experimental methods used in the top half of the circle testing for effectiveness and efficacy should be used in conjunction with the methods located in the lower half of the circle testing for effectiveness and safety. As a result of this work, Walach has developed an argument for using particular combinations of research evidence when reaching decisions about the clinical use of any medicinal intervention. At present, however, there are an insufficient number of studies of the types required to use the '*Circle of Methods*' (Fig 5, p.140) in assessing the evidence for the use of homeopathy for specific conditions. At present the range of studies are too disparate and further research is required.

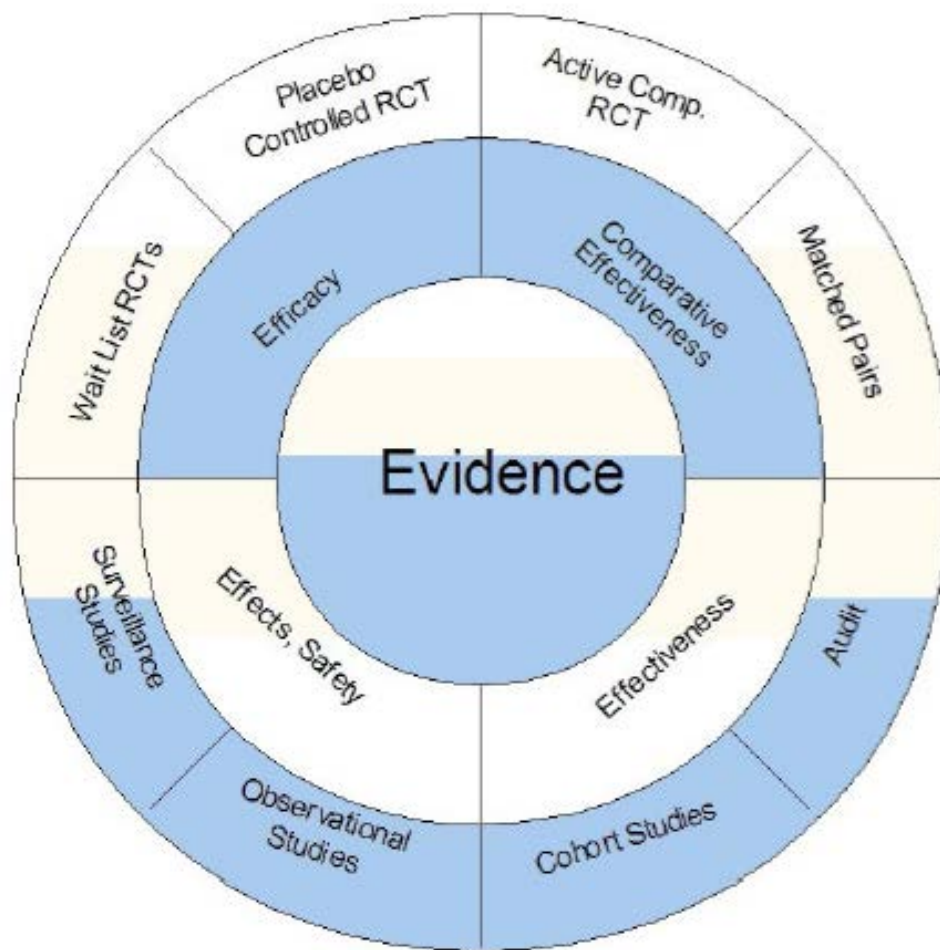


Fig 5: Circle of Methods (Walach, Falkenberg, Fonnebo *et al* 2006, p.5)

Although used by many mothers and midwives, homeopathy does not have an evidence base, that meet the requirements of EBM as it is currently interpreted. Midwives consistently report this lack as a barrier to its use (Mitchell, Williams, Hobbs *et al* 2006 Williams and Mitchell 2007, Mitchell and Williams 2007, Cant, *et al* 2012). As a consequence and because its degree of benefit/risk cannot be quantified it is considered to be too risky to be sanctioned for use by midwives in many trusts (Mitchell, Williams, Hobbs 2006, Cant, Watts and Ruston 2011).

### 3.6 Conclusion

In line with the Cochrane Review into the induction of labour (Smith 2009), I similarly found that the clinical studies, researching the use of homeopathy as interventions in maternity care, failed to meet the quality standards required. For example, the Boltman (2005) study confused herbal and homeopathic medicine, whilst others were either methodologically flawed or poorly reported (Hofmeyer 1990, Ventoskovkiy et al 1990, Atmadjian et al 1998, Dorfman et al 1986, Beer and Heiliger 1999, Berrebi et al 2001, Oberbaum et al 2005). Additionally, many of the studies were very small or pilot studies and as a consequence underpowered. The review of clinical studies demonstrated the clear need for studies to conform to defined and accepted methodological and reporting standards. Such studies could then be used as part of a '*mosaic of evidence*', '*typological triage*' or '*circle of methods*' as envisaged by Reilly (1993), Petticrew and Roberts (2002), and Walach et al (2006).

A revisioned pyramid of evidence would countenance the inclusion of the practitioner and patient voice. For example the survey data in this review shows that practitioners are offering CAM therapies and service users are making use of them. There appears to be support for the use of CAM by midwives and midwifery managers in the United Kingdom on the grounds that they enhance choice, improve health and promote normality (Williams and Mitchell 2007, Hall and Jolly 2014). There is also evidence to suggest that midwives recommend service users to CAM (Jones et al 2013). Additionally, the Avon study (Bishop, Northstone and Green et al 2011) one of the largest surveys conducted found that of the fourteen thousand, one hundred and fifteen women surveyed 14.4% had used homeopathy during the maternity episode. Whilst it is not always possible to separate homeopathy from the other modalities reported in the surveys, where specific figures are available for its

use, they range between 2% and 14.4%. These figures would suggest that in the UK a large number of women are choosing to explore and use some type of CAM during their pregnancy, with a proportion of these women making use of homeopathy. The use of CAM is associated with significant benefits both to women and midwives. For women it is seen as a way of promoting normal childbirth, reducing medical intervention and empowerment. For midwives CAM aids job satisfaction, promotes normal childbirth and allows them to provide good quality, holistic, creative and individual care.

The literature reveals a dissonance. Maternity professionals and midwifery managers assert their support for CAMs; service users, as consumers, appear to want to use CAMs; yet the political landscape appears not to sanction them being offered by midwives in NHS settings. The studies reveal the presence of constraining factors such as a lack of funding, a lack of time, concerns about competence, lack of evidence, fear of litigation, lack of knowledge about the benefits of CAMs, a lack of autonomy in the midwifery profession, unsupportive colleagues and medical staff, notions of risk, lack of consensus about the appropriate practice boundaries, and the incompatible positions adopted by biomedicine and CAM.

Where qualitative research has been conducted it is generally broadly based, examining the experience of midwives in a wide range of CAM practices. Whilst there are quotes from midwife homeopaths in the literature reviewed, these quotes tend to be about their opinion about the benefits of CAM and factors that enable or constrain its use. The literature identified treats CAM as a homogeneous entity rather than as a group of discrete practises. Although these practices may share

some similarities there are also substantial differences that impact on their availability and use. Further in-depth research that examines the impact of studying homeopathy on midwives and their practice is needed.

In the following chapter I consider the methodology for this study.

## **Section Two: Data Collection**



## **Chapter Four: Theoretical perspective and methodology**

In Chapters one to three I discussed the context for the study and articulated a range of on-going debates in midwifery and homeopathy. The debates include those surrounding choice, risk and the nature of evidence. In doing so, I considered the research trials of homeopathy in maternity care and explored the literature surrounding the use of homeopathy by service users and maternity professionals. The review revealed a number of surveys that showed large numbers of mothers use CAMs to support them during their maternity episode. The surveys also suggest that where CAM use is outside the NHS mothers do not always inform their midwives and other health professionals about what they are using. The literature suggests that there is an epistemological impasse between the underlying philosophies of homeopathy and midwifery. It is in practice that the impact of the managerial/technocratic context of risk averse health care can be identified.

### **4.1 Introduction**

The literature review uncovered no previous studies that examined the experience of midwives who have studied homeopathy. I believe that it is key, therefore, to explore the narratives of midwives attempts to engage with homeopathy and how they manage the impact of this in practice. In this chapter I lead the reader through my deliberations as I considered a range of research theories to frame my study, before setting out my reasons for choosing a phenomenological approach.

## 4.2 Aim of the study

The aim of the study is to explore the experience of midwives who seek to become experts in two professional disciplines, one of which is currently framed in the current '*normal science*' (Kuhn 1970) of standard health care provision: midwifery; and the other which tends to stand in opposition to these health care norms: homeopathy. My intention is to analyse how they manage to do this, and assess the impact it has on them both personally and professionally.

Crotty (1998, p.3) suggests the researcher starts by identifying the methodologies and methods that will be used in the study. The methodologies are '*the strategy, plan of action, process or design lying behind the choice and use of particular methods, and linking the choice and use of methods to the desired outcomes*'. The focus of this chapter is to consider the relationship between my research question, goals and conceptual framework. Chapter five includes an examination of the methods adopted for this study.

## 4.3 Ontology and Epistemology

When conducting any research study I consider it important to explore one's own ontology and epistemology, and the influence this has on the aims and design of the study. A research paradigm contains three elements: ontology, epistemology and methodology (Crotty 1998). These elements are in turn supported by the methods chosen. Ontology is the study of being and encompasses our notions about the nature of the world and the things in it. Epistemology is concerned with the theory of knowledge and the way we understand and explain how we know something. For Crotty, ontology sits beside epistemology informing the theoretical perspective of the study. Each theoretical perspective encapsulates a particular way of

understanding '*what is*' (ontology) as well as a particular way of understanding '*what it means to know*' (epistemology) (Crotty, 1998, p.10). I recognise that my own experience as a researcher influences both the methodology and methods chosen when '*doing*' my research. Kuhn (1970) highlighted that for any given community or discipline there is a specific range of beliefs, values and methods of solving a puzzle. He called this a paradigm. It is recognised that the discipline within which individuals are taught exerts a strong influence upon the way in which they learn to view the world. The definition of a paradigm has been extended from its focus upon specific disciplines, and now encompasses basic human beliefs, world-views and constructions that guide action (Denzin and Lincoln 1994). Hence, the way I 'see' the world led to the research topic '*Straddling Paradigms: an interpretive hermeneutic exploration of the experience and practice of midwife homeopaths*'. This statement reflects my own paradigmatic stance, representing as it does, my particular view of the nature of the world, my place as an individual in it and the way that I relate to it (Guba and Lincoln 1994, p.107). Davis-Floyd and St. John (1998) outline the advantages of this, stating that by adopting a paradigm the researcher conducts a study that possesses a very clear theoretical model. However, they note the importance of the researcher remaining aware of the possible influence of the paradigm on the research. Therefore, they believe that a researcher should be explicit about their own theoretical position and also acknowledge the value of personal interpretation.

#### **4.4 Objectivist or Subjectivist**

Western medicine has generally developed a tradition of empiricism, positivism and materialism, greatly valuing the scientific method. (Wilson 2000). Mattingley (1988), taking an anthropological view, states that justified by the empiricist and essentialist understanding of reality, biomedicine employs a means-end rationality. Traditional

science is firmly embedded within this objectivist philosophy as developed by Descartes (1596-1650), Newton (1642-1727), Comte (1798-1857), Mill (1806-1873), Durkheim (1859-1917) (Downe 2008, Collis and Hussey 2009). In this paradigm, observations and measurements can be made objectively and subsequent researchers can repeat these observations and measurements. For those who adopt a positivist approach there is only one reality, dividing and studying the parts can lead to an understanding of the whole. Crotty (1998, pp.5-6) defines objectivism as the:

*View that things exist as meaningful entities independently of consciousness and experience, that they have truth and meaning residing in them as objects and that careful research can attain that objective truth and meaning.*

Within the objectivist paradigm, the researcher is considered to be neutral. The possession of a positivist view leads to the adoption of methodologies that are designed to explore a hypothesis. These are likely to be quantitative and experimental. However, despite this belief in an objective truth, bias can occur during the planning, data collection, analysis or publication phases of the studies, and researchers aim to avoid this by careful design of studies (Gerhard, 2008).

In contrast a subjectivist approach suggests that there can be no objective reality. The subjective approach helps researchers understand why things are the way they are in the social world and why people act in the way they do. The subjective approach is very much concerned with understanding from another's perspective, and qualitative methodologies constitute a way of eliciting this data. Subjectivity guides the researcher in the choice of the issue to be researched, in the selection of methodology and the way the data is interpreted. Collis and Hussey

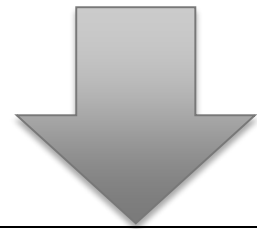
(2009) suggest that a number of alternative terms are used to describe the research paradigms. These are outlined in the following table (Table 7).

Alternative Philosophical Paradigm Names	
Objective	Subjective
Quantitative Positivist Scientific Experimentalist Traditionalist	Qualitative Interpretivist Phenomenological Humanistic

Table 7: Alternative Philosophical Paradigm Names (Collis and Hussey 2009)

Cresswell (2012) summarises the philosophical assumptions that underpin these paradigms in Table 8.

My perspective



	<b>Positivism</b>	<b>Interpretivist</b>
<b>Ontology</b>	Naïve realism –‘real’ reality but apprehensible	Relativism – local and specific constructed realities
<b>Epistemology</b>	Dualist/objectivist, findings true	Transactional/ Subjectivist /constructionist Creates or constructs findings
<b>Methodology</b>	Experimental/manipulative; verification of hypotheses; quantitative	Hermeneutic/dialectic
<b>Nature of knowledge</b>	Verified hypotheses established as facts or laws	Individual reconstructions coalescing around consensus
<b>Values</b>	Excluded – influence denied Propositional knowing about the World is an end in itself, is intrinsically valuable	Included – formative
<b>Axiology</b>		Propositional, transactional knowing is instrumentally valuable, which is an end in itself, is intrinsically valuable.

Table 8: Philosophical assumptions underlying research paradigms (Cresswell 2012).

## 4.5 Interpretivism

As can be seen in Table 7, authors differ in the terms they use when describing the subjective research paradigm. Lincoln and Guba (2000) discuss the constructivist/constructionist/interpretivist paradigm, Neuman (2014, p.103) calls it ‘*interpretive social science*’, whilst Cresswell (2012) uses interpretivism and social constructionism interchangeably. Crotty’s (1998, p.42), definition of constructionism, appeals to my own beliefs:

*‘.....the view that all knowledge, and therefore all meaningful as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context’*

I believe that researchers and participants are inter-dependent. The question I want to ask is best answered using a constructionist approach. This enables participants to provide rich, deep and complex answers to the researcher and provide valuable insights that may otherwise be missed using a quantitative approach (Strauss and Corbin 1990). A constructionist approach considers that human beings constantly interpret the world they engage with. Without this interpretation the world would lack meaning (Guba and Lincoln 2001). According to Heidegger, a phenomenologist, the world is *‘always already there’*, and it is the engagement of Dasein<sup>29</sup> that creates meaning for human beings (Alweiss, 2003). Heidegger uses the term ‘Dasein’ to describe *‘This entity which each of us is himself’* (Heidegger 1962, p.27), and *‘that entity which in its Being has this very Being as an issue’* (Heidegger 1962, p.68). By adopting this approach I am able to create the world through the story as narrated by the study group and construct meaning through it. Mason (2002, p.63) illustrates the constructionist researcher’s way of *‘knowing’* and *‘being’* in that s/he would hold an ontological position that *‘people’s knowledge, views, understandings, interpretations, experiences and interactions are meaningful properties of the social reality which [their] research questions are designed to explore’*. This, Mason continues, is congruent with an epistemology that considers it acceptable to *‘interact with people, to talk to them, to listen to them, and to gain access to their accounts and articulations’* in order to generate data. This study recognises that research participants make sense of the world around them in different ways. Consequently, the study is concerned with discovering the individual

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<sup>29</sup> Dasein: the term is used to describe Heidegger’s notion of the existence of being that is peculiar to human beings.

meanings as experienced by those who are being researched to enable an understanding of their view of the world rather than my own (Denzin and Lincoln 1994, Jones 1995). Underpinning constructionism is the notion that meaning is neither simply objective nor subjective, and it brings these together in a meaningful way. There is a relationship of intentionality between subjects and objects in order to create meaning. Crotty (1998, p.44) states that '*what we have to work with is the world and objects in the world*'. The world and what is in the world are '*our partners in the generation of meaning*'.

For meaning to exist, there must, according to Brentano (1838-1917), be intentionality. In introducing this notion, Brentano (1995, p.88) stated that:

*'every mental phenomenon is characterised by what the Scholastics of the Middle Ages called the intentional (or mental) inexistence of an object, and what we might call, though not wholly unambiguously, reference to a content, direction towards an object (which is not to be understood here as meaning a thing), or immanent objectivity. Every mental phenomenon includes something as object within itself'*

It is this notion of intentionality that influenced Edmund Husserl, the founder of phenomenology. What intentionality refers to has, according to Crotty, been further developed by phenomenologists, who have extended the meaning to encompass that no object can be described if isolated from the conscious being who experiences it. Similarly nor can any experiences be described in isolation from its object (Crotty 1998).



I was influenced by the writings of Crotty (1998) when considering the relationship between my own epistemology and how this relates to the theoretical perspective, methodology and methods selected for my study (1998). I have adapted Crotty's diagram (1998, p.5) to demonstrate this relationship between these various elements and these appear in Table 9 below.

Epistemology	Theoretical perspective	Methodology	Methods
<i>Constructionism</i>	<i>Interpretivism</i> * <i>Phenomenology</i> * <i>Hermeneutics</i>	<i>Phenomenological research</i>	<i>Interview</i>

Table 9: Relationship between epistemology, theoretical perspectives, methodology and research methods (Adapted from Crotty 1998, p5).

#### 4.5.1 Justification for an interpretive approach

When exploring the combination of my personal ontology and epistemology and the research question, phenomenology and hermeneutics frequently appeared and reappeared. The question for me was to determine whether my study could best be described as phenomenological, hermeneutical or as hermeneutic phenomenology. In considering this, the number of different interpretations of and approaches to phenomenology became apparent (Stewart and Mickunas, 1990; Spiegelberg 1982). Caelli (2000) found there to be 18 forms of phenomenology in existence. Of these, Hamill and Sinclair (2010) chart three chief schools: Husserl, Heidegger, and the Dutch Utrecht School of Phenomenology. As well as being a research philosophy phenomenology is also used as a research tool.

It is by exploring the perspectives and contributions made by Husserl and Heidegger that the location of my own research will be made clearer.

## 4.6 Phenomenology

Weininger (2014) defines Phenomenology as the '*descriptive science of phenomena*' whilst Smith (2011) describes it as the study of structures of consciousness as experienced from the first person point of view. It has become established as both a popular research methodology and method for many nursing research projects (Norlyk and Harder 2010). Van Manen (2007, p.12) calls phenomenology '*a project of sober reflection on the lived experience of human existence*'. There are essentially two distinct phenomenological approaches, descriptive phenomenology developed by Husserl and Giorgi; and hermeneutic (interpretive) phenomenology as advanced by Heidegger, Gadamer and Merleau-Ponty). The following section will explore the evolution of phenomenology via the contributions made by its main proponents.

Cresswell (2013) believes that whether a study can be considered to be phenomenological depends on the presence of a number of features. For Creswell, phenomenological studies examine a single concept or idea with a group of individuals who all share experience of the phenomena. There should be a philosophical discussion about the basic ideas involved in conducting a phenomenological study. The participants should have both subjective experience of the phenomenon and objective experience in common with other people in the study. The data is most frequently obtained by interview, but can also include poems, observations, and documents. The analysis of the data is systematic, eventually summarising '*what*' individuals have experienced and '*how*' they have experienced it, before going on to discuss the '*essence*' of the individual's experience (Cresswell 2013).

The contributions made by Husserl, Heidegger, Gadamer and more recently by Smith, are detailed in the following section. Following this a discussion of the hermeneutic circle will take place.

#### **4.6.1 Evolution of phenomenology: the contribution of Husserl, Heidegger and Gadamer**

##### **Edmund Husserl (1859-1938)**

Edmund Husserl, as a mathematician, wanted the knowledge generated by philosophy to have a secure, irrefutable base. Husserl's approach was positivistic (Dowling 2007), and the aim was to study things as they appear, to enable an essential understanding of human consciousness and experience. In developing his ideas around phenomenology he wanted to be able to describe phenomena leaving aside any of the assumptions that are part of our ordinary existence. He considered that the phenomena should present its essence to us, as we all have our individual experience of the world, and is each in possession of a natural attitude that influences our understanding of it. He proposed that we neutralise this natural attitude by '*bracketing*' it as a way of stepping back and looking only at the phenomena. Husserl's idea of bracketing was derived from his mathematical ideas. By bracketing the researcher puts aside all assumptions (Crotty 1996, LeVasseur 2003), perceptions (Rose, Beeby and Parker 1995) experiences, knowledge (Beech 1999), biases and beliefs (Dowling 2004) and pre-judgements (Moran 2000) that might shape their data collection or change their way of understanding and working with the data (Crotty 1996, Polit and Beck 2004). Husserl's philosophy did not encompass an interpretation of the experience as for him the '*life world*' was about an individual's pre-reflective experience (Crotty 1996).

The desirability, or otherwise of this has been the subject of debate amongst researchers. It is argued that by bracketing the researcher can take an etic view thus uncover the participants own reality rather than a Heideggerian emic approach which fuses the world of the researcher with that of the participant so that the final research is a co-construction (Hamill and Sinclair 2010). Brentano's (1938-1917) work on intentionality was highly influential on Husserl's own work. '*Intentionality*' is the concept that every mental act is related to an object and this suggests that all perceptions have meaning. According to Van Manen (1990) this translates as all thinking is about something.

### **Martin Heidegger (1889-1967)**

Martin Heidegger, a German phenomenologist, was concerned with the nature of being, and what it means 'to be' human beings. Heidegger questioned the concept of being, believing three common prejudices to exist, mitigating against our attempt to understand it (Weininger 1999). The prejudices include that we consider '*being*' as the most universal concept, that we are not able to define it and that it is self-evident to us (Heidegger 1962, 25). It is argued that because both the question and answer about what it means '*to be*' are so simple this demonstrates how large the problem of understanding '*being*' really is. Heidegger termed this experience of '*being*' as '*Dasein*', stating that Dasein exists for human beings precisely because we ask about it. As humans we already possess an understanding of being, even if we do not clearly understand it.

This is one of the areas where Heidegger differs from Husserl in his approach. Where Husserl proposes that we bracket and look at the phenomena in its own right, Heidegger wants us to understand Dasein in its '*average everydayness*'. It is this everyday way of existence that is itself the phenomenon (Weininger 1999). Heidegger considered that our essence lies in our existence and that each of us is fundamentally an individual who are thrown into the world as individuals. Dasein can only be found within an environment. Alongside other Dasein we might encounter in this environment there are also other entities which can be either '*present at hand*' (the things which simply are such as objects of nature), or '*ready to hand*' (the being of tools, and things available to us to be used).

For Heidegger the notion of time is different for both Dasein and the objects that appear in the world. Time as a continuous string of identical moments through which all entities remain the same works well for objects that are '*present at hand*' or '*ready to hand*', but does not work for Dasein because Dasein is always projected to the future, and we are constantly aware of our possibilities, which he calls '*understanding*'. Dasein can choose to exist authentically or inauthentically. If we become '*bothered*' and '*get caught up*' in the world, or we ignore the possibilities of our own Dasein we can become lost in this world of things and the opinions of others, this Heidegger calls '*fallenness*' and thus we are rendered inauthentic. To be authentic requires that we take responsibility for ourselves and the possibilities open to us. We can *choose* to actualise the possibilities and live authentically, and when we do this we become projected into a future where '*not being*' or death is a reality for us. Whatever we do or engage with thereafter so long as we remain authentic is always accompanied by this sense of death or '*not being*'.

The nature of Dasein and its relevance to the midwives narratives will be explored in detail in chapter seven.

### **Hans-Georg Gadamer (1900-2002)**

Heidegger was highly influential in the development of the philosophy of his one-time student Hans-Georg Gadamer. Gadamer worked on exploring the notion of '*philosophical hermeneutics*', an area started but left unfinished by Heidegger. For Gadamer, it is our '*belongingness*' to the world that allows us to experience things as meaningful to us. He then argues that this is achieved through our mastery of language, and this allows the world to become unlocked for us. We cannot, he believes begin to understand ourselves unless we accept that we exist within a language-mediated culture. However, unlike Schleiermacher and Dilthey (Gadamer 1975) who believe that simply by correctly understanding and interpreting a text the original intention of the writer can be known he states that this can only happen when there is a '*fusion of horizons*' (Gadamer 1977). This recognises that the interpreter is fashioned by their history and culture understanding occurs when the interpreter finds the point where the text's history and their own background intersect. In essence a person belonging to the world, interprets that world.

### **Jonathan Smith**

There are modern variants within phenomenology, notably Interpretative Phenomenological Analysis (IPA as) developed by Jonathan Smith (Smith 2014). Initially developed as an approach in psychology IPA it was subsequently applied to other disciplines. In common with other phenomenological approaches it seeks to

understand lived experience and the way that study participants make sense of their experiences (Smith 2014). There are many reasons why IPA could have been considered for this research. Not least the emphasis it places on understanding individual or group experience in considerable depth. To do this it is usual in IPA to use a very small sample, sometimes as low as one, but generally no more than 15 (Pietkiewicz & Smith 2014). The interviewing technique is largely the same as for other phenomenological studies, however the analysis has its roots within the psychological disciplines. Pietkiewicz & Smith (2014, p.11) state that the analysis is achieved by *'looking at the data through a psychological lens, interpreting it with the application of psychological concepts and theories which the researcher finds helpful to illuminate the understanding of research problems'*. They argue that by taking an *'emic'* perspective the researcher can avoid psychological reductionism. However, I chose not to use IPA for this study, instead favouring the approach suggested by Smythe *et al* (2008). Smythe *et al* (2008) describe the experience of *'doing'* Heideggerian hermeneutic research, and the application of this approach to my own research is discussed in Chapter 5 (p. 168).

#### **4.7 Hermeneutics (the hermeneutic circle)**

It is Heidegger, and subsequently his student Gadamer, who are credited with the development of the hermeneutic circle (Dobrosavljev 2002). Initially concerned with the understanding of biblical texts, over time hermeneutics extended into philosophical enquiry. The hermeneutic approach is an attempt to understand phenomena rather than just provide an explanation. The approach stresses that text can only be truly understood when both the whole text and each of the individual parts are understood with reference to each other. When this happens it becomes a hermeneutic circle. Heidegger uses the hermeneutic circle when examining *'The Origin of the Work of Art (1935-1936)'*. Heidegger suggests that neither art works and artists can be understood

without reference to each other, and neither of them can be understood away from 'art' which in itself cannot be understood apart from the former two (Heidegger 1971).

Crotty (1998, p.92) perhaps more succinctly, describes the hermeneutic circle as '*to understand the whole through grasping its parts, and comprehend the meaning of parts through divining the whole*'

Gadamer continued with the development of the hermeneutic circle. He saw it as an iterative process that allowed the interpreter to reach a new understanding of reality based on the exploration of the detail of existence found in text.

Dahlberg *et al* (2010), in their discussion of hermeneutics and phenomenology, regard hermeneutics as philosophically linked to Heidegger and Gadamer, and methodologically to Van Manen and Giorgi. Hutton (2012, p.2) states that the epistemological assumptions of phenomenology can be described as the '*method of investigation and identification of phenomena and is reflective of an individual's interpretation of events*', whereas, the epistemological assumptions of hermeneutics '*lie in the process of discovering hidden meaning in the form of textual analysis, which also considers the sociocultural and historic influences of inquiry*'. For Van Manen (1990), hermeneutic phenomenology is research aligned toward lived experience and the interpretation of 'texts' of life. Although hermeneutics and phenomenology are distinct both philosophically and methodologically, they can be used in conjunction with each other (Laverty 2003)

## **4.8 Conclusion**

In this chapter I have engaged with the philosophical underpinnings of the methodology



chosen for the study. I have considered the aims of the study and reviewed the guidance offered by Crotty (1998), Cresswell (2013), Guba and Lincoln (1994) and Van Manen (1997, 2007). I have presented my rationale for being guided by Heideggerian phenomenology. This provides a framework to explore and interpret the midwives stories, using the knowledge gained in the background and literature review. I am concerned with trying to understand the experience of midwife homeopaths as experts in the field and to '*make sense*' of their experience. I want to explore their personal perceptions and accounts and the meanings that they place on their experience.

In the next chapter I describe the design and methods chosen for the study.

## Chapter Five: Study Design and Methods

### 5.1 Introduction

In the previous chapter I presented my ontological, epistemological and theoretical approach for this study. I determined that an interpretive hermeneutic approach guided by the writings of Heidegger and Gadamer would be adopted. I now turn to an examination of the methods chosen for conducting the study. Crotty regards research 'methods' as *'the techniques or procedures used to gather or analyse data related to some research question or hypothesis'* (Crotty 1998, p.3). Crotty believes that the methods chosen emerge from the methodology adopted by the researcher (Crotty 1998).

### 5.2 Methods

#### 5.21 Sampling: Participants and setting

Deciding on a sample in qualitative research is complex and can be confusing, not least because of the inherent flexibility and lack of guidance surrounding the process (Coyne 1997, Englander 2012). It is said that researchers should be both adaptive and creative when designing their sampling strategies, and should attempt to be responsive to real world conditions that enable them to meet the information needs of the study. In this instance, the participants needed to be able to tell me what it is like *'being'* a midwife homeopath. Consequently, to be able to answer this question they needed to be qualified in both midwifery and homeopathy, but not necessarily currently working as a midwife or homeopath. When taking account of the literature I decided that the participants experience during this period remained relevant to the study objectives (Cant *et al* 2012). A purposive sampling approach allowed for the specific recruitment to the study of those possessing the experience and ability to answer the research question and provide the rich data needed for the

study (Morgan 2013). Crookes and Davies (2004, p.151) define purposive sampling as:

*'judgemental sampling that involves the conscious selection by the researcher of certain subjects or elements to include in the study'.*

Therefore, the criteria for inclusion in the study were that participants should:

- be qualified as a midwife, *and*
- hold a practising qualification in homeopathy

The participants were also required to be willing to fully engage with the interview and recount their experiences (Seidman 2012).

I planned to recruit participants via the professional registering bodies, NHS trusts, colleges, colleagues and my own contacts. However, after the publication of the Mitchell and Williams (2007) study, I decided not to recruit midwife homeopaths through NHS Trusts as the survey found that only 11 units offered homeopathy. As these units were not identified, I considered it too burdensome for them to be asked to provide similar information, especially when it could be found using alternative, more focused approaches.

As a first step I contacted the Nursing and Midwifery Council (NMC) and the Royal College of Midwives (RCM), however neither maintain a list of midwives who are qualified in complementary therapies. Similarly, the organisations registering homeopaths do not collect data on members holding nursing qualifications (Society of Homeopaths, Alliance of Registered Homeopaths, Homeopathic Medical Association). The Faculty of Homeopathy, as an organisation recognising

statutorily registered practitioners would hold such information, but at the time of the request had no midwives registered with them.

I decided that a more direct route to access this group of midwives was required, and I conducted an Internet search to identify dual qualified practitioners. I also contacted colleagues who I knew were qualified as midwives or homeopaths to ask if they knew of anyone that met the inclusion criteria.

When attempting to determine the optimal size of the sample, I found wide variation in the guidance provided. Cresswell (2013) reports phenomenological studies where the number of participants has been as low as 1 (Dukes 1984), up to as many as 325 (Polkinghorne 1989). Cresswell (2013, p 5) considers that in a phenomenological study '*long interviews with up to ten people*' are optimal. Englander (2012) suggests no less than three, whilst Dukes generally recommends between three and ten participants. Morse (2000, 2001) considers that the sample size in qualitative research studies requires the researcher to take into account the scope of the study, the nature of the topic, the quality of the data, and the study design, whilst Giorgi (2009) believes that it is the depth and quality of the data obtained that is important, not simply the number of interviews undertaken. Englander (2012) in discussing sample size states that the phenomenological researcher seeks to explore the experience of the phenomenon, not how many people have experienced it. In doing so, the phenomenological researcher does not attempt to address issues surrounding generalizability or representativeness. Groenwald (2004), however, suggests using the notion of '*data saturation*' to guide sample size. This is the point at which no new information or themes are found in the sample. The notion of theoretical saturation is derived from Glaser and

Strauss's (1967) work on grounded theory, although there is debate about its utility in phenomenological studies. Guest *et al* (2006, p.59) suggest that:

*'although the idea of saturation is helpful at the conceptual level, it provides little practical guidance for estimating sample sizes for robust research prior to data collection'.*

Taking into account the various recommendations for the number of study participants required in a phenomenological study I settled on between six and ten participants. I determined that this would allow me to obtain both the depth and quality of data I sought to obtain.

A number of dual qualified practitioners were identified and information sheets sent out via email addresses. Of these, seven practitioners responded stating that they had read the information sheets and were happy to be participants in the study. Although this was on the lower side of the number I had initially sought, I decided to interview these participants and then, if necessary, ask them if they knew of any midwives qualified in homeopathy who would be eligible to take part in the study, a process known as snowballing. All the midwives responding who met the criteria for the study were interviewed. The interviews lasted between 50 and 80 minutes. Both the shortest and longest interviews took place via telephone. Of the seven respondents, two had been fellow students of homeopathy in the mid 1990's (n=2), one participant had trained as a homeopath at UCLan (n=1), and four participants came via homeopathy colleagues (n=4).

I had not been in regular contact with any of the participants since training with them or lecturing on their course. However, the homeopathy community is relatively small, and as I had been both a director of the Society of Homeopaths and an

educator on a pre-registration homeopathy course it is highly unlikely that I would be able to find a complete group of participants where I was unknown. Nevertheless, I had to consider the impact that knowing the participants might have on the study. Seidman (2012), states that knowing the participants can create problems when interviewing the participants. He suggests that when the participant and researcher know each other they may assume a shared understanding about the topic. This means that instead of exploring comments and statements made by the participant the researcher believes they already know what the participant means. Whilst it is not possible to assess whether the information obtained would have been different had three of the participants not already been known to me, by knowing that this was a real possibility, I took great care not to make these kinds of assumptions by constantly challenging myself and adopting a reflexive approach.

## **5.22 Ethical issues**

Ethics approval for the research was obtained through the University of Central Lancashire Faculty of Health Ethics Committee. Full ethics approval was obtained in January 2009.

When undertaking any research, there are ethical issues to be considered. The first of these is whether the research contributes something useful to the existing knowledge base, and in this instance the study will provide a clearer description and deeper understanding of the experience of this group of midwives and the subsequent impact on their practice of having studied homeopathy. This will feed into the current debates on the delivery of care (and caring) in the National Health Service.

A further consideration is the likelihood of harm to the participants. Beneficence is a fundamental requirement of all research (Polit and Beck 2004), and requires that the researcher consider the welfare and benefit of others. Whilst there is no direct personal benefit to the midwives in the study, they were advised of its purpose, and that findings would be published in the academic literature and presented at appropriate conferences. Non-maleficence requires that there is no intention to harm the participants in any manner (Beauchamp and Childress 2013). For this study the participants gave their consent after reading the participant information sheet, and asking relevant questions. It was not anticipated that the interviews would cause distress, although one midwife after reflecting on the information given in her interview asked that the information not be used in the study. The remaining midwives thought that the information provided by them was accurate, and the transcripts were available for them to look over.

Additionally, when undertaking any research project each participant should be allowed to make their own fully informed decision about whether to take part in the research and their choices respected. The information sheets (Appendix 3, p.333) were designed to provide sufficient detail about the study for the midwives to give informed consent, and midwives could contact me on the telephone number or email address provided for more information if they wished. The participants were also informed that they could withdraw from the study at any time without providing a reason. Signed consent forms (Appendix 4, p.336) were returned by the midwives prior to the interviews taking place.

The principle of justice requires that all study participants are treated equally and are not unfairly coerced into taking part. Participants were chosen as they met the inclusion criteria, suggesting that they would have the experience to inform the study. All women were given the same information about the study prior to interview. Whilst the study participants are not expected to directly benefit from their participation in the study it is expected that it will be of benefit to other midwives and women.

### **5.23 Confidentiality**

The participants were all assured that I would take steps to protect their privacy and confidentiality. Pseudonyms have been selected to protect their privacy. Primary data will be kept on an UCLan password protected computer after completion of the publication of the PhD in accordance with UCLan requirements.

### **5.24 The interviews**

The purpose of the phenomenological approach is to find out how phenomena are perceived and experienced by the participants. The aim is to gather deep, comprehensive and textured information and perceptions by using inductive, qualitative methods. The use of interviews allows a researcher to understand both a participant's experience and the meaning they ascribe to their experience (Seidman 2012). During the interviews I aimed for using unstructured interviews approach with each participant. I am familiar with this type of interview, and I believe that it enables participants the freedom to tell their story in depth (Sechrist and Pravikoff 2002).



I also had to remember however, that these were research interviews rather than therapeutic interventions or friends catching up with each other's news.

Notwithstanding this, I wanted to achieve a similar depth in each of the interviews.

Nelms (1996, p.369) states that:

*'When we listen for the stories of our colleagues or clients we are practicing hermeneutically and, as such, hermeneutics has the potential to increase our understanding of our everyday lives, transform our thinking and create for us a future of new possibilities'*

## **5.25 The phenomenological question**

The aim of the study as outlined in section 1.4 of the thesis, was to explore the experience of midwives as they sought to become experts in two professional disciplines, one based within an NHS that operates on neoliberal principles: midwifery; and the other which tends to stand in opposition to this: homeopathy.

The quest in a phenomenological study is not to provide concrete answers, instead it is to reveal the experience of the participants. In the interviews I wanted to explore how each participant had experienced their journey; the events or feelings that had triggered it; the way they and others had responded to them; how they developed as a result of their experience and the impact of this on their practice. I believed that this would provide the data needed to 'think' about the phenomena of being a midwife homeopath. I chose to use unstructured interviews for collecting the data, thus allowing the participants freedom to tell their story in their own way. The participants were free to determine the direction the interview would take. Although I use unstructured interviews within my homeopathy practice I had not previously used them when interviewing research participants. The research interviews were qualitatively different. For instance, I was able to use a recorder and this enabled me to give my full attention to what the participant was saying. It

felt quite liberating not having to take verbatim notes of the conversation, and I hadn't realised how this had previously impacted on my '*being there*' and '*present*' in the interview. This was the case both with the telephone and face-to-face interviews. I wanted the participants to feel comfortable and unfettered in the telling of the story. I also believed that the process would allow this to happen. However, as part of my planning, should any participant have struggled to describe their experience, I decided to develop a number of questions that could be used as prompts. These included:

- Why did you train as a homeopath?
- Has the study of homeopathy impacted on your practice as a midwife?
- If it has, how has your practice changed?
- If it hasn't, why is this so?

Usually the participant is given the choice about the interview location to allow for comfortable surroundings, however because of the distances involved and participants working patterns, I offered participants the choice of face-to-face, telephone or Skype™ interviews. Five participants chose a telephone interview, whilst the remaining two chose face-to-face meetings. The interviews were recorded and transcribed. I let the participants decide the length of the interviews, believing that they would conclude spontaneously (Holloway and Weaver 1998). The use of telephone and Skype™ interviews also gave the participant much greater freedom in the timing of the interviews. Evenings and weekends were suggested, and these were times that would otherwise not be possible because of the distances involved, and the working patterns of the participants. Jessica and Emily chose face-to-face interviews whilst the remaining participants chose the telephone. The participants who lived some distance away stated their preference for a telephone interview.

Whilst it is not the most commonly used method, telephone interviews have been, and continue to be used in phenomenological research. Several concerns have been expressed about this use, with the claim that, in addition to the lack of rapport and empathy, there may be a loss of contextual and non-verbal data (Novick 2008). Novick believes the reason for this concern is that there is considerable bias against the use of telephone interviews and they are often seen as being a much less desirable method than face-to-face interviews. He suggests that the use of a telephone may be beneficial in allowing a participant to feel relaxed and able to disclose personal or sensitive data. He argues that there is no evidence that would support the hypothesis that telephone interviews inhibit the collection of quality data. Sweet (2002) conducted a phenomenological study with nurses and found telephone interviews to be both methodologically and economically valid stating that qualitative researchers should not solely rely on face-to-face interviews.

In establishing rapport with the participants so that they felt they could talk freely about their experience and feelings, I had to decide on how much, if any, self-disclosure I would be happy with. In determining this I decided when setting the scene for the research that I would share information about my professional status as both homeopath and university lecturer, but I would also be as honest as possible if participants asked me questions. Kvale (1996, p.128) considers that:

*'the first minutes of an interview are decisive. The subjects will want to have a grasp of the interviewer before they allow themselves to talk freely, exposing their experiences and feelings to a stranger'*

I needed to take account of the fact that three of the participants were known to me, and therefore were already aware of my background. With these participants I decided to spend some time before the interviews so that we could catch up with

each other's news before starting the interview. I had not seen some of the participants for a significant time, so doing this enabled me to re-establish rapport, and to help both of us feel comfortable in a new situation. For me, it created a bridge between the old and the new, and enabled the participant to concentrate fully on disclosing their personal narratives. During the interviews I also took the opportunity to reflect back to the participants so they could correct me if I had misunderstood what they had said.

All the participants had received the participant information sheet and had the opportunity of asking any questions before deciding to give their consent for the interviews. They were also asked to consent to the audio recording of the interviews. Audio recording enabled me to give my full attention to what the participant was saying, and meant that I did not need to take any notes of the meeting; apart from my own journal entries after the interview had taken place.

A short time after the conclusion of the interviews one participant contacted me expressing her wish to withdraw from the study. She felt that there was a strong possibility that she could be identified from the information she had provided. During the interview she had been very open about her experiences, particularly with respect to her continued employment as a midwife, and was fearful of the potential ramifications from the inclusion of her data.

### **5.3 Data analysis**

Research interviews generate a large quantity of data and notes that require analysis. Initially I considered the use of data analysis software such as NVivo or

MaxQDA to help with the analysis. NVIVO and MaxQDA do not reduce the active role of the researcher in the analysis of the data, but are designed to speed up the data handling so allowing more time for exploration and analysis of the data.

Coding is an important element of making sense of the data, and the choice of whether to use manual or electronic methods depends on the size of the project, the time available and the expertise and inclination of the researcher (Basit 2003). The process of understanding interview data depends on the researcher refining their understanding throughout the research analysis from the raw data through to the finished product and even beyond. I chose to manage the data manually, in part this was because there were a limited number of interviews, but more importantly I wanted to become immersed in the interviews in a way that I did not think possible for me using a computer programme.

When undertaking an analysis guided by phenomenological principles it is important to adopt a phenomenological attitude to the research by reading the interviews and looking for meaning whilst working closely with the detail. An article published by Smythe *et al* (2007) entitled '*Heideggerian hermeneutic research: As lived*' was influential in the way I approached the data. Particularly, noteworthy was how they describe how '*techne (knowhow)*' has diminished our use of '*lived phronesis*'. The authors' state that the researcher is always, already in, their own research. This is because the researcher is living the experience of their research, and they are attuned to possibilities inherent within it (cf. p.161). Smythe, Ironside, Sims *et al* (2007, p.1391) call the researchers choice '*to do it this way*' as '*resonance, attunement and a sense of goodness of fit*'. They continue by stating that '*everything from our past lies within the soil from which thinking arises and bears fruit*'. The researcher concurrently engages with the philosophy of Heidegger and

other phenomenologists so that they are ready for the moment that the '*possibility of understanding opens*' to them.

I wanted to transcribe the interviews myself. The reasons for this were two-fold.

The first reason is that I could reduce the number of errors in the text (Halcombe and Davidson 2006), and the second to enable me to continue with the process of engaging with the midwives stories. It is by living with the stories, reading and re-reading them, and reading philosophical texts that my own insights begin to occur. Some things quickly become apparent, yet others remain hidden from view.

Gadamer calls this the space where we are free to '*play*', so that understanding and interpretation can be reached. Dunne (1993) calls the thing that allows '*things to be revealed*' as '*thinking*'. It is '*thinking*' that allows things to be revealed, not by '*working out*' but instead it happens through a '*letting come*'.

In the light of this, once each interview was transcribed, I read and re-read the text. This process continued for some time, and as I attempted to reach a place of understanding the data were catalogued and coded into themes and sub-themes. The midwives stories were viewed separately and also gathered together so their collective experience could be understood. I '*played*' with the data allowing patterns to reveal themselves. These were later related to existing literatures. Theme statements were generated to capture the meaning inherent in the data. To make sure that I was at ease with the interpretation of the midwives stories, I spent time re-listening to the interviews whilst reflecting on the stories. This process took time, as I attempted to immerse myself in their world and understand their experience. Following the principles in Gadamer's hermeneutics it is not possible to examine each story independently from the meaning of the whole text, or the whole text

without reference to each story. There is a mutual dependence: individual text elements change their meaning following the whole and the whole changes with its parts. The hermeneutic circle is open and transparent circle allows concepts to flex and change with time, it is open and transparent. (Dobrosavljev 2002)

### **5.3.1 Introduction to the interpretive lenses**

In chapters six through to eight, the data is examined using three interpretive lenses. The three lenses were developed whilst I was working with and '*immersed*' in the data. My process is outlined in figure nine on p.177. The first step was to manually transcribe the interviews (Appendix 9), as I believed this would help me to immerse myself within the stories as told by the midwife homeopaths. Subsequent to this I '*played*' with the stories to better understand the nuances, and see the possibilities that were inherent in them. As I read and re-read the transcripts, and continued to read Heidegger's works, my understandings changed. As Smythe et al (2007), citing Dunne (1993, p. 268) explained, '*we can never freeze our assets, nor is there ever a period of respite in which we might prepare ourselves for action as if that were something in which we not already involved*'.

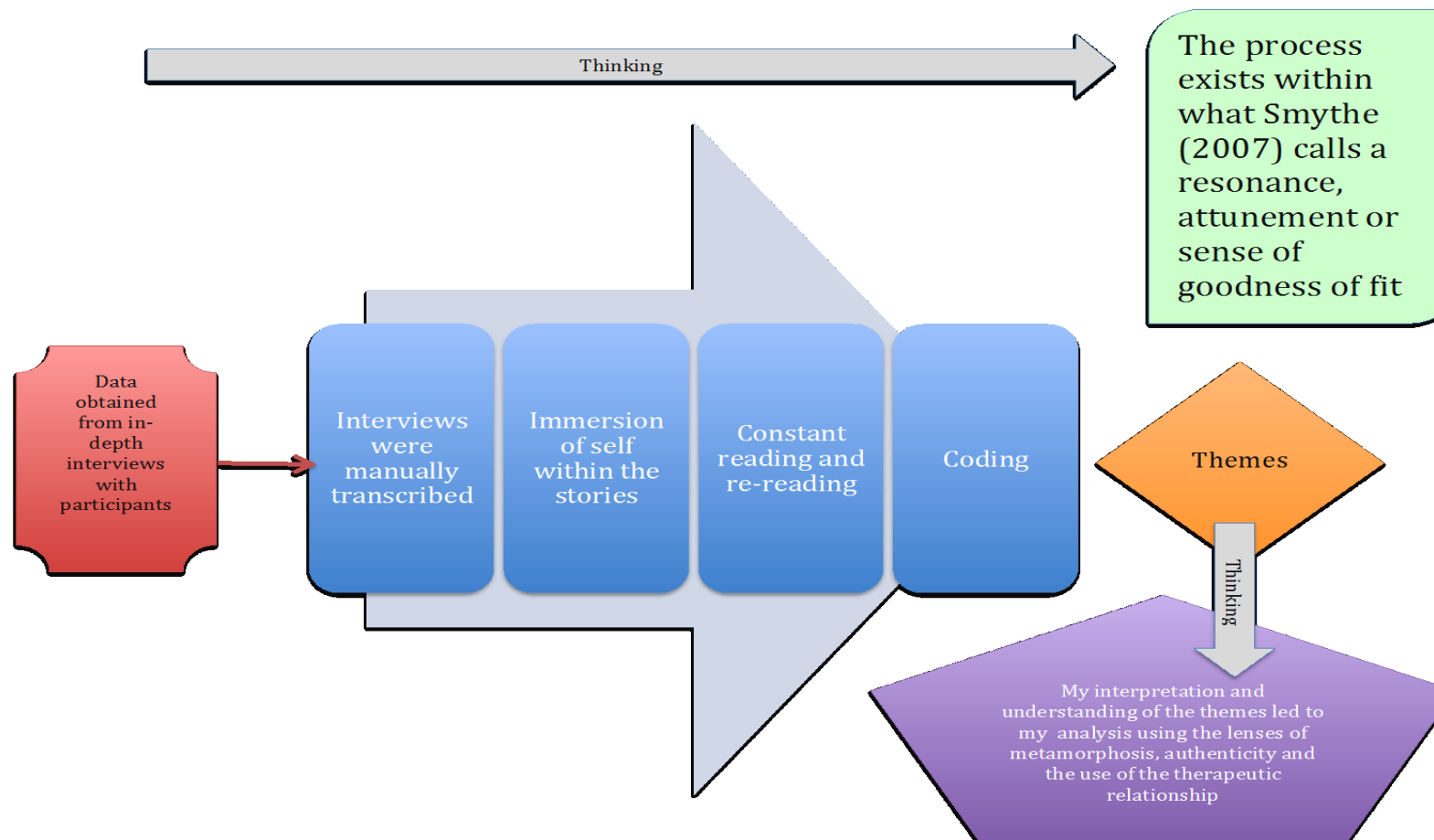


Figure 9: Process of data analysis



Initially, my aim was to understand the midwives stories as they were reported to me. The diagram (Appendix 10) shows my preliminary understandings of their narratives. The participants were introduced to homeopathy through caring for themselves, or a relative whose needs were not met by existing health care practices. As a result of their experience with homeopathy they chose to train as homeopaths, some for their personal use, others because they saw its potential within their midwifery practise. Whilst training, participants observed both support and antipathy towards homeopathy from colleagues. All of the participants experienced some degree of derision about homeopathy, and this in conjunction with an inability to use homeopathy led to some participants choosing to leave the NHS in favour of practising homeopathy. Those who remained in the NHS felt they had learned to adapt their practice, stating that '*homeopathy is not just about the remedies but the way that you practise*' (Zoe). These themes were represented in Table 10.

Table 10

<p>Theme 1</p> <p><b><i>Sparking the flame</i></b></p> <p>Outside the mainstream</p> <p>The lightbulb moment</p> <p>Not getting any better</p>
<p>Theme 2</p> <p><b><i>Playing by the rules</i></b></p> <p>They thought I was crackers</p> <p>Struggle</p> <p>No! No!</p> <p>Watching me</p> <p>Workaround the rules</p> <p>Sceptics</p> <p>Medical control</p> <p>Rebellion</p> <p>The system</p> <p>Dotting the 'i's' and crossing the 't's'</p>
<p>Theme 3</p> <p><b><i>Throwing stones – Rules, reasons and rhetoric</i></b></p> <p>Time</p> <p>Money, money, money</p>

Clinical governance Fear of litigation Insurance Risk Evidence
Theme 4 <b><i>Tying my hands</i></b> Limiting my autonomy Women's choices Homeopathy in midwifery
Theme 5 <b><i>The fork in the road</i></b>
Theme 6 <b><i>Homeopathy not just about remedies but the way that you practice</i></b> Enhancing skills Seeing and hearing women Learning to live with it
Theme 7 <b><i>To thine own self be true</i></b>

At this early stage my understanding of the data was preliminary and superficial. As my understanding deepened I started to view the data through three lenses. The first lens, '*metamorphosis*' encompassed all the themes previously noted in table 10 through the personal and professional metamorphoses of the participants. Secondly, in chapter seven, the participants transformation into authentic practitioners was examined and analysed through the use of Heideggerian concepts and language (Appendix 11). The final lens, developed in chapter eight, explored the impact of being authentic and re-engaging with the therapeutic relationship on the relationship developed by the midwife homeopaths and the women in their care.

Each of the chosen lenses made a contribution to my understanding and interpretation of the midwives experiences. The lens '*metamorphosis*' enabled me to see their transformation as a process of significant change and development.

The application of Heideggerian '*authenticity*' provided a framework to understand the changes that occurred and the result of this change was the re-engagement of the midwives with the therapeutic relationship.

### **5.3.2 Trustworthiness of the data**

Debate exists on how best to determine the quality of a piece of phenomenological research (Shenton 2004, Langridge 2007). Johnson et al (2001) maintain that phenomenological researchers rarely use a '*pure method*', stating that the rigid adherence to any particular research method is neither necessary nor more likely to increase validity. The primary aim of phenomenological hermeneutic research is to represent the phenomenon under investigation as closely as is possible to how it was experienced by the participant (Guba 1981).

At the same time I also need to recognise and make clear my own subjective position so that my pre-understandings and interpretive efforts are recognised. To enable this a personal diary was maintained to enable critical reflection, and this enabled me to trace the development of my pre-understandings through my developing understanding to my current understanding of the data. This process enabled me to constantly revisit my personal beliefs and assumptions. This process was aided via regular '*active listening*' discussions with my supervisors.

Data were analysed through three lenses. The first, detailed in chapter six, captures the findings of the study using the metaphor of '*metamorphosis*'. The second lens analysed in chapter seven, references these findings in Heideggerian philosophy. The third lens (chapter eight) frames the data within notions of the

therapeutic relationship, and links back to current notions of '*compassion and caring*' in postmodern healthcare.

## **5.4 Conclusion**

This chapter has provided an overview of the design of the project. Ethical issues and access to the participants and recruitment have been discussed. The research design and methods used for the study have been considered, as well as issues of trustworthiness of the data.

In section three of my thesis I firstly present the findings from the study using the metaphor of '*metamorphosis*'. Subsequent to this I turn to theorising the findings using the concept of Heidegger's '*authenticity*', and the impact of this authenticity on the development of the therapeutic relationship between a midwife and women in her care.

## **Section 3: Findings**

## **Chapter Six: Findings: Metamorphosis to midwife homeopaths**

### **6.1 Metamorphosis to midwife homeopaths**

In the previous chapter I presented and discussed the methodology and methods for the research study. In this chapter, I present the findings from the study. Firstly, I introduce the reader to the midwives and provide a little information about each before presenting their stories. The data has been divided into a number of overarching and sub-themes, each theme contributing to the totality of their experience and ultimately growth and metamorphosis. These themes form the basis of the sections presented in this chapter. As a phenomenologist, it was very important to me to present the findings in the participant's own words wherever possible. I consider that by using their own words their authentic voice can be heard. My interpretation of their narratives will be explored in chapters seven and eight.

### **6.2 Introduction to the participants**

The sections in this chapter portray the findings from my interviews with the six midwife homeopaths who remained in the study. A discussion about the midwife who withdrew from the study will take place within section 6.7 of the thesis. Of the six midwives (Grace, Zoe, Emily, Gina, Jessica and Chloe), five trained as midwives first and then as homeopaths and one trained as a homeopath first and then as a midwife. Of particular note is that whilst only two participants have continued to practice as midwives in the NHS and one as an independent midwife, they are all still practicing as homeopaths. There was one participant still practising as a midwife who withdrew permission for the inclusion of her data. The chart below outlines their current practise as midwives and as

homeopaths. Zoe, Chloe, Grace and Gina were interviewed by telephone whilst Emily and Jessica were interviewed in a face-to-face setting. The participants had all been sent the information sheet prior to the interviews taking place. They were all very frank and keen to share their experiences with me. The interviews flowed well with very little prompting required, although these were available if required.

**Table 11: Participants current practise as midwives and as homeopaths**

Participant	Practising as a midwife	Practising as a homeopath
Zoe	Yes (NHS)	Yes (Non NHS)
Emily	Yes (NHS)	Yes (Non NHS)
Chloe	No	Yes (Non NHS)
Grace	No	Yes (Non NHS)
Jessica	No	Yes (Non NHS)
Gina	Yes (Independent)	Yes (as an Independent midwife)
Tina	Yes	Yes

The midwives' names have been changed and pseudonyms have been used to ensure their confidentiality (NMC 2008). The midwife who withdrew is referred to as Tina. The numbers beside their names relates to the original transcripts of the interview and the line number of the relevant section of text.

The midwives who took part in the study were:

### **Zoe**

Zoe trained as a general nurse and then as a midwife in the 1970's, before working as a nurse caring for the elderly. After training as a homeopath Zoe completed a 'Return to midwifery' course and now works as a midwife in the NHS. Zoe is also the Risk Manager for her maternity unit. In addition, Zoe maintains a small private homeopathy practice.

### **Emily**

Emily trained first as a general nurse and then as a midwife in the 1970's and early 1980's. After training as a homeopath Emily worked in a GP practice and, as the GP was a practicing homeopath, was able to offer homeopathy to women. After the GP's retirement, and a restructure of her Trust, Emily's use of homeopathy as a midwife was restricted. However, Emily retains a small private homeopathy practice.

### **Chloe**

Chloe trained as a general nurse then as a midwife in the 1970's, working in a variety of practice settings including a GP surgery, home for the elderly and as a community midwife. Chloe now works as a homeopath in private practice.

### **Grace**

Grace, a general nurse and midwife, worked as a community midwife for 13 years before training as a homeopath. Grace gave up practising midwifery and now practises solely as a homeopath in private practice.



### **Jessica**

Jessica trained as a general nurse and midwife, practising as a midwife for 20 years before training in homeopathy. Jessica gave up midwifery practice and now practises as a full time homeopath in private practice.

### **Gina**

Gina trained in homeopathy prior to training as a midwife in Australia. On arriving in England she worked first as a general nurse and then in a birthing centre. Gina is now an independent midwife who uses homeopathy as part of her practice.

### **Tina**

Tina trained as a homeopathy after training as a general nurse and midwife. At the time of the interviews Tina was working part time as a midwife in a consultant unit in a large regional hospital and also maintained a small private homeopathy practice.

The midwives in the study although uniquely individual, also share some common experiences and feelings. When embarking on their journeys to becoming midwife homeopaths the five participants, who were already midwives, did not expect their lives to unfold in the way they did. Before then homeopathy was not something they had considered or even known about. As they strive to care for others in a way that they are comfortable with, each encountered unexpected obstacles, and made choices that enabled them to feel at ease with themselves. The participant who was already a homeopath before she became a midwife, although her trajectory

was different still experienced many of the same barriers to homeopathy practice in the NHS.

It was after reading and re-reading, or '*thinking*' about their stories using a hermeneutic phenomenological approach that the ideas of a personal and professional '*transformation*' emerged. Initially, my thoughts were of the midwives following a journey, and whilst they are, I also came to realise that their stories were much more than simply taking a journey. They were also fundamentally changed and transformed by their experiences and this had a direct impact on their midwifery and homeopathy careers. Consequently, the story I am going to present is of the midwives '*metamorphosis*'. '*Metamorphosis*' has been used as the overarching metaphor to represent the midwives experiences as they encounter and emerge through various stages of development.

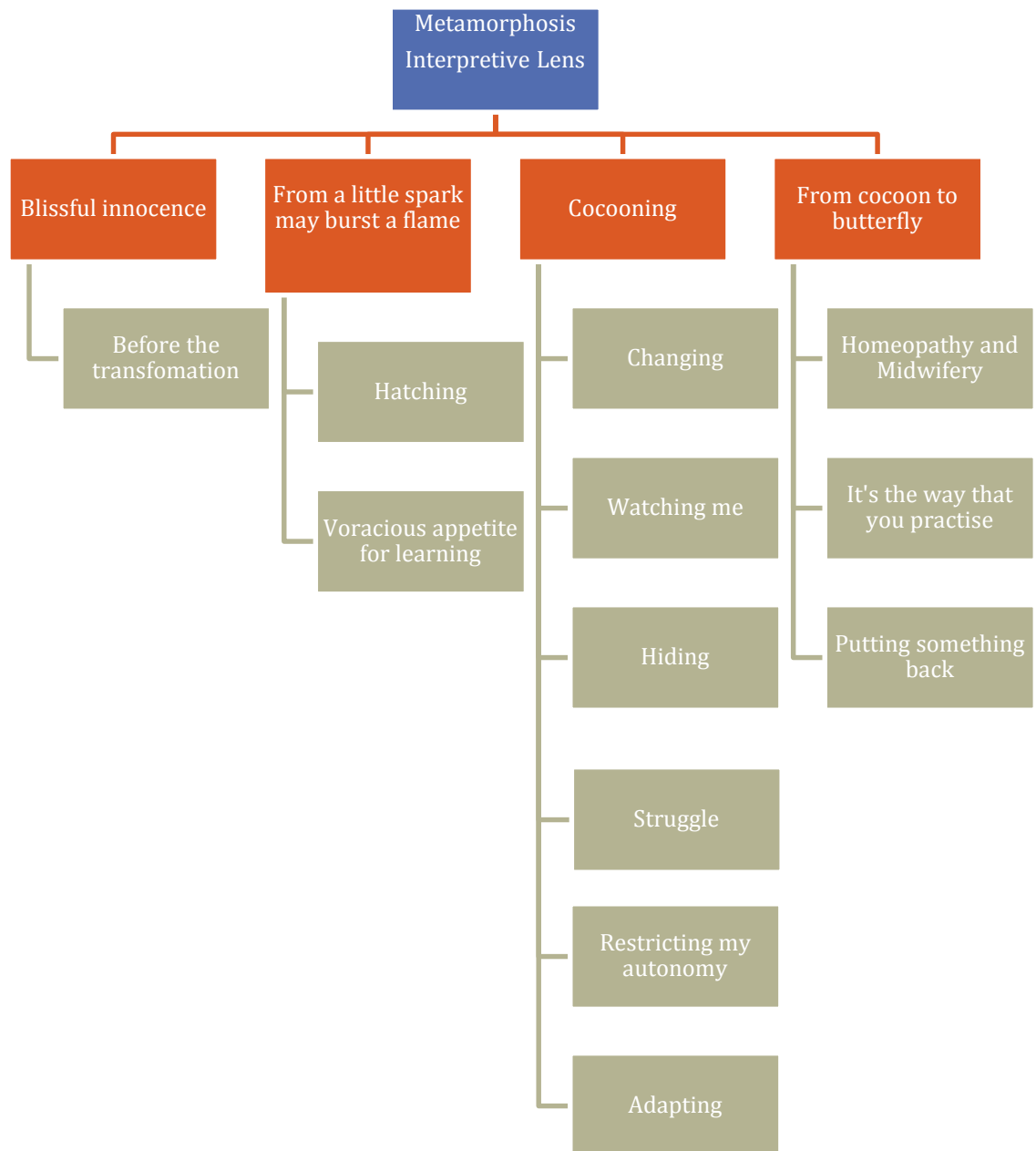
The first of these, entitled '*Blissfully innocent*' describes the midwives before they became fully aware of homeopathy. At this time five of the midwives were yet to have the experiences that led them to the study of homeopathy. They reported themselves as being perfectly happy in their world. This '*blissful innocence*' is seen metaphorically as the first stage of their metamorphosis from egg to butterfly.

The subsequent section is entitled '*from a little spark may burst a flame*'.

Metaphorically, this is the larval stage of metamorphosis and explores how the midwives became aware of homeopathy as a possibility. They each experienced an '*epiphany*', that led them to want to learn more about homeopathy. This section explores their desire to learn and describes how they develop through this process.

The metaphorical chrysalis stage is termed '*cocooning*' and narrates their experience when attempting to transfer their learning into practice, whilst the final stage is '*from Cocoon forth a Butterfly*' depicting the eventual emergence of the butterfly. Quotations from the interviews are used to enable the midwives voice to be heard through their stories.

Fig. 6 Themes and subthemes in the study.



Orange boxes = overarching themes

Green boxes = subthemes.

I have used direct quotes from the interviews believing that this helps to communicate the meanings the midwives offered on their experiences. It also allows the reader insight into how the themes came about. Where quotes illuminate different aspects of the findings and discussion they are used more than once.

The midwives started their accounts with stories about the event(s) that sparked off their search for alternative modes of treatment, and this experience is reviewed in the section entitled 'sparking the flame'. However, before this, I want to describe the way they reflected upon their own histories. Each had a vision of themselves before homeopathy was illuminated as a possibility for them. I have chosen to call this '*blissful innocence*'.

### **6.3 'Blissful innocence'**

#### **6.3.1 'Before the transformation'**

When the participants reflected upon their personal and professional lives prior to the illness they described how they had been very happy and satisfied with their lives and midwifery practice.

The midwives had previously worked as nurses and midwives in an array of settings. Not all had been located in what might be termed the '*holistic paradigm*'. For instance, Emily recalled how she had previously been very firmly positioned in the biomedical model and had approached both her midwifery and her life from within this very 'conventional model' (42). Zoe, in contrast, felt that she had '*always*

*looked at the holistic side of things, I mean when I worked in (town) I taught psychoprophylaxis which was a combination of yoga and meditation as an aid to pain relief'* (Zoe: 75-79). It was yet a different story for Gina, who had studied both acupuncture and homeopathy first before deciding to train as a midwife. Gina, a childbirth educator had worked with many pregnant women and their children before training as a midwife. She reports that she always saw things in a holistic way, saying that *'I never liked the medical model and right from the beginning of my training intended to become independent'* (Gina: 58-60). Only Gina had known anything about homeopathy at this point in their histories.

The five participants who were midwives prior to being midwife homeopaths agreed that, at one time or other, they had all shared a sense of *'loving' being a midwife*. Chloe says that she *'went as a district midwife and loved it'* (Chloe: 19); with Jessica reporting that she *'absolutely loved being a midwife, and that is why I was there for 20 years'* (Jessica: 232). The language used by the midwives demonstrated their depth of feeling for the job they were doing. When recalling their past they are unequivocal about how much they enjoyed being midwives, Jessica describes midwifery as a *'vocation'* (232) and a place where you *'longed to go everyday... everybody just helped each other out and always the women were there at the centre, and the women and their babies and families were always at the forefront of our practice'* (32-35).

In the next section I explore the reasons why the midwives chose to study homeopathy, especially above all the other modalities that were open to them. I also want to examine the personal changes they undergo whilst doing so.

## 6.4 'From a little spark may burst a flame'

This theme explored the participant's experiences that led them to homeopathy, first as a patient, then as a practitioner. All of the participants had faced a health crisis within the family and their response to it turned out to be a pivotal moment in each of their lives. It is the point where their views changed, enabling them to choose to take a very different path. These episodes were such that the participants believed that conventional medicine could not deal with the issue adequately, or the treatments had too many side effects, or fellow medical professionals had treated them unprofessionally. Without the illness they may never have learned about homeopathy.

Emily reports that her son was ill, explaining that he had:

*'had his first ear infection at three months old and it was only because I was trained that I could hold him so that they could get the otoscope in his ear and confirm it, and the diagnosis was confirmed and the GP said that babies of this age don't get ear infections, so he then went on to get ear infections on a regular basis (39-42). On hearing this Emily asked for a referral believing that 'at this rate he is going to be deaf by the time he is two if we don't do something', only to be told that 'Oh we don't do anything at this age because they don't get ear infections' (44-45).*

So not only was Emily's son ill, but the doctor failed to acknowledge her experience, dismissing it out of hand.

Grace had a similar experience with her daughter who she says:

*'was about four years old, and had recurring otitis media, which was diagnosed as glue ear. She was having infections in her ear every two weeks and every two weeks she would be on antibiotics and it went from Amoxicillin to Septrin....her eardrum had perforated and all this discharge was coming out. So I took her back to the GP just to see if the eardrum had healed really and he*

*said that there were a lot of fluids still in that ear etc. she must take this Dimetane... I had half a dozen bottles at home which he prescribed each time she had an infection alongside the antibiotics and I said it wasn't right, so didn't give it to her' (3-16).*

She says that she just said to him:

*'I'm really sorry but I don't think she ought to have it because it just knocks her out literally and he sort of rose up in his chair and said 'I work with Mr X at the ENT hospital and all the glue ears have this for 2 months' ...I can remember it so clearly because I felt so humiliated and distressed, humiliated and kind of crawled out on my belly thinking 'who am I, just a nurse and a midwife and what do I know about anything' kind of thing that they can make you feel, and went home, gave it to her for 24 hours and it just knocked her out, she couldn't function' (17-23).*

Chloe's reports a very similar experience, and discussed how her daughter suffered from allergies and asthma as a baby. Chloe became deeply unhappy when her doctors suggested that her daughter be prescribed a steroid inhaler. A colleague suggested she try homeopathy, something she had not come across before:

*When my middle daughter was five she had problems with her health for two years, lots of coughs... diagnosed a milk allergy when she was five. The doctors wanted to put her on steroid inhalers for her asthma. I thought No, and I think it was one of the girls I worked with that suggested homeopathy. Chloe (29-33)*

When they sought medical treatment for themselves and their families, both Emily and Grace were shocked and then distressed at how they were treated by people they considered as colleagues. They were also extremely concerned about the treatments offered. Emily didn't receive treatment because '*babies don't get ear infections*' whilst Grace felt the treatment offered was likely to compromise the health of her baby. Chloe was dismayed at the thought of her daughter using a steroid inhaler, perhaps for many years.



Zoe's story was slightly different in that it did not concern a child, but rather she told me of her husband's cancer diagnosis. She recalled how she wanted to find something to help him with the side effects of his treatment. She says of homeopathy that she '*saw that it worked so well*' (64) for him.

For Jessica it was her own issues with her health that sparked the change, Jessica told the story of being:

*quite ill with gastritis.... when my son was being bullied and I recognised that it was all stress related and I went down the route of going along and having a gastroscopy, taking the LOSEC, doing everything I was expected to do, knowing full well I wasn't getting any better' (4-7).*

For Gina, the event that she describes as shaping her outlook on life, and informed the choices she made happened much earlier in her life. As a child her mother had severe rheumatoid arthritis, and she remembered how she '*looked at how she kept getting worse and worse no matter what the doctors did for her*' (127-129). This left Gina questioning conventional medicine as she was growing up, asking herself why it failed to help her mother. She recounted that this led to her exploration of possible careers in alternative medicine, first acupuncture and then homeopathy. It was only after training in alternative medicines and working with women that she decided to train as a midwife, fully intending to go down the independent route.

*'Well I think that I probably see things in a more holistic sort of a way, I have never liked the medical model and right from the beginning of my training I intended to become independent' (58-60)*

#### 6.4.1 'Hatching'

The midwives commented on their decision to seek treatment from a homeopath. They knew they had reached a point where they knew they were unhappy with conventional treatment, but discuss how they generally needed something or someone that pointed them towards consulting a homeopath. This prompt came from sources as diverse as family, friends and colleagues. In Chloe's case it was a colleague who suggested it. At the time of the suggestion she was unaware of homeopathy and what it might offer to her. She says how *'One of the girls I worked with ...suggested homeopathy. I hadn't heard of it, so researched it, and found a homeopath... a doctor who did homeopathy on the side'* Chloe (33-35). At first Chloe, being firmly rooted in the biomedical model was only prepared to take her daughter to see a medically qualified homeopath. She believed that only someone with medical training had the requisite skills to treat her daughter. It was only some time later on seeing the results that she decided she wanted to train as a homeopath.

Grace decided on homeopathic treatment for her daughter, even though she knew very little about it at the time. It was not a rational decision she said, but instead a choice she made because she felt she had very few options open to her within the conventional model on offer. She describes how she:

*'thought I can't do this to my child so at this point she had started school and I decided, I just said to my husband at the time, I am going to find a homeopath, not really knowing what it was about, not knowing anything about anything really and just thought it is an alternative medicine'* (24-27).

For Emily, it was simply a matter of starting what she describes as a *'trek of looking for something else'* (44). At that time in her life she was just certain that she did not want the treatment suggested to her by her doctor.

The participants described their perceptions about the treatments they received.

Jessica explained how:

*'she got phenomenally better in a very short space of time'* (11),

whilst Emily reported how the homeopathy *'treated (her son) very successfully'* (46).

Similarly Chloe stated how she:

*'threw away the inhalers as all the problems cleared up and (she) got really interested in it (35-36)... she did brilliantly'* (43).

Being successfully treated by a homeopath made the midwives consider their views about health. Emily and Zoe both felt that they had always held 'holistic views'.

Emily stated that:

*'my views have always been women centred, family centred rather than highly medicalised, so it actually sat quite comfortably with me'* (55-56).

This was not the case for Jessica though, who came to realise that homeopathy required her to *'look at a different structure towards .... health'* (40). She reflected on this saying that:

*'it is actually giving the focus back to you rather than a plaster which is basically conventional isn't it, like sticking an Elastoplast on it, you know if you have got this we will treat that, but we don't treat that, it has to be somebody else, if you have got something wrong with your liver and your lungs, well we can only treat your liver you have to go and see a lung specialist, so there isn't that sort of continuity of care or recognition of the fact that it can all be just one central*

*disturbance in the body that is creating all these problems in all these organs, they just look at the organ itself* Jessica (41-47)

After seeing the benefits of homeopathy for themselves the midwives developed an interest in its practice. Chloe said that she *'got interested myself...thought I could do this! So I got the books and read up about it'* (43). Grace felt that *'the more (she) got to know... the more (she) wanted to know'* (41-42). Chloe describes this interest saying how she *'was blown away by the philosophy of it all'* (87).

It was this interest that led to some of the midwives making a momentous decision for themselves and embarking on professional training as homeopaths. Jessica and Emily describe the moment when they knew what they wanted to become homeopaths. Emily called it a 'light bulb moment' (46), whereas Jessica describes how the decision just came *'out of the blue one day'* Jessica (9-10). Other participants reached a more gradual realisation that they wanted to study homeopathy. Zoe reported that she wanted to study homeopathy because she had seen that *'it worked so well for'* (75) her husband before he passed away.

The midwives felt that they each had a vision about the type of homeopath they would be, and where they would practice. Some aspired to combining homeopathy and midwifery. For instance, Emily's vision was to be *'an independent midwife, so (she) could more easily incorporate it to run a mums and baby home birth service'* (35-37). Chloe, Zoe and Gina shared this vision of combining midwifery and homeopathy, albeit in the NHS, whereas Jessica had already made the decision not to combine the two disciplines stating:

*'I didn't want to try to do homeopathy alongside midwifery as I wouldn't have got the time off for the weekends.... (or) to go to the clinics' (12-13).*

In contrast, Grace only wanted to treat her family and friends saying that her:

*'aim was not to be a practitioner of homeopathy but just for my own benefit and for the benefit of my own children really, just wanted to know what I was doing so that I could treat my family that was my aim at that time' (43-46).*

#### **6.4.2 'Voracious appetite'**

Once the midwives had made the decision to train as a homeopath and embarked on their training they demonstrated an enormous appetite for learning as much as they could about homeopathy. They became highly motivated students with a huge desire to learn as much as they were able. Chloe describes how she was 'blown away with the philosophy of it all' (87), and Grace reports how 'the more I got to know...the more I wanted to know' (42-43). By this time Grace had also changed her mind about practice, and whilst initially she had only wanted to know more for her family she now realised that:

*'once you are in it you realise that you have all the knowledge and that you have to practice because you can't not practice when you have all this knowledge' (49-51).*

Some participants described how they became attracted to and continued to study homeopathy because they perceived it as being holistic. Importantly they had started to feel that this was missing in their midwifery practice. Grace explains how she had come to think that the '*allopathic method and model of healthcare had no foundation*' (153-156). She continued by saying that in her opinion homeopathy was:

*‘based on natural laws, because the research hasn’t changed in homeopathy in 200 years, based on truth, whereas today’s bit of research in the science world is ok today but will be discredited tomorrow’ (153-156).*

Once the process of change had been initiated (*hatched*) the midwives, other than Gina, decided to go public and tell their colleagues, extended families and their NHS trusts about their plans. I decided to use the metaphor of *‘cocooning’* for this emergent theme.

## **6.5 ‘Cocooning’**

‘Cocooning’<sup>30</sup> is used to describe the participants’ experiences (Zoe, Emily, Chloe, Grace, Jessica) as they complete their homeopathy training and beyond. Gina’s experience was slightly different. Whilst cocooned the insects are rapidly changing; however during this time they remain vulnerable to attack. The midwives are similarly undergoing a transformation as they train and find themselves in what they perceive as an unfriendly, alien environment. This section will describe and explain the changes that happen to them.

### **6.5.1 ‘Changing’**

Change is an essential element of any metamorphosis, and for these midwives the changes were significant. Emily says that *‘the whole way I look at life as a person, as a midwife has changed by what I have learned through homeopathy’* (118-119). The change that occurred for Grace was also noteworthy as she remarked how her *‘values changed as (a) result of studying homeopathy’* (153). Alongside these changes came difficulties reconciling the new values with their old practice. Chloe

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<sup>30</sup> ‘Cocooning’ – although a cocoon is a silk case that moths, and sometimes other insects spin around the pupae I have used the term as a verb, to describe the period of time between the larvae pupating and the butterfly emerging.

observed how she *'found it difficult, the more I learned about the philosophy, the more I hated my job'* (49-50).

During this period of change the midwives experienced a myriad of different reactions from colleagues, employers and sometimes their friends. Grace recalled that she felt let down by her colleagues when she made a decision not to take up the offer of a Hepatitis B vaccination. As a result of her studies she had become concerned about the side effects of vaccination:

*as I got further into the course and doing my midwifery, the powers that be and I ran into trouble for the Hep B jab and that took 9 months to resolve during which time I was prevented delivering (babies)'* (58-61).

Some of the midwives had suddenly found themselves in an environment that no longer felt hospitable. Even though they had previously loved their jobs, once their own views had shifted they found it increasingly hard to fit in. They were not able to act in a manner that was congruent with their altered values. Jessica explained how she would feel:

*Frustrated, that's why I wouldn't go back. I couldn't, I wouldn't want to, wouldn't say I couldn't, wouldn't want to look after women and give them conventional treatment, drugs things like that when I know how much better it could be for them using homeopathy, and then I just wouldn't be able to use that at all. That would not be an option at all Jessica* (105-108).

*'I wouldn't want to be dishing out pethedine to people when I can see a far better way forward'* Jessica (125-126).

The reaction of others to their changing personas varied. Jessica remembered how *'they were curious as to why I would want to do it after 20 years in midwifery'* (73). She was told that they thought *'it was hilarious, they thought I was crackers!'* (57-58). Grace's experience was similar and she said how she:

*'was viewed as a bit of an oddball.., because I was going against the grain, not only was I practising homeopathy, but I had also refused vaccination' (149-150).*

Other colleagues were more dismissive of the midwives, with a colleague of Jessica's saying to her *'what the hell are you doing'* (75). She said that *'there wasn't anyone (medical) who said 'well that is fantastic'* (76-77). Jessica also experienced small pockets of support, this often came from other midwives. Jessica reports how a few colleagues *'on the midwifery side of things....said 'that's great'* but they also asked *'what is it'* (78). Grace on the other hand felt *'totally supported by colleagues'* (148), whilst Chloe recalls how other *'midwives were interested'* (89).

Although at work Jessica had found little support from the medical staff she spoke of how her *'own GP (was) one of (her) clients now'* (55). Other's had a contrasting experience and found doctors that expressed a professional interest, with one *'want[ing] to do a study on vomiting to see how homeopathy could help in pregnancy'* Chloe (94-95).

Both Zoe and Jessica found their managers to be encouraging. Zoe *'talked to the modern matron who was so supportive'* (166-167), and Jessica felt that she had *'some really good managers who can take on board these other alternative approaches, (a) more holistic approach'* (287-289).



### 6.5.2 'Watching me'

Grace who felt unsupported talked about how she felt she was under constant surveillance during her training and after qualifying as a homeopath. Grace had what she felt was a particularly bad experience and said that she:

*'felt there was a bit of a witch-hunt going on and I almost felt like when I was in that work situation I had to really watch myself, I couldn't leave any 'i' un-dotted or any 't' uncrossed in my practice and I almost felt like it was a bit of a waiting game for me to make a mistake and slip up so then they could get rid, as this person was not doing what everyone else was doing' (165-170)*

*'I was going against the grain, that is what it felt like, I don't know if it was like that, but the chamomile tea incident didn't help, to be pulled up for something as ridiculous as that, I suppose compounded the feeling that I had to watch my back, unfortunately that is how it was'. (170-173)*

*'at management level, my direct manager, but she was only following instructions, it must have been discussed, for a midwife from the wards to scuttle down to the offices to complain about it...there must have been some discussion amongst the managers, it would not have been her decision.' (173-177)*

Grace's experience is at the extreme end of the spectrum experienced by the midwife homeopaths, although Jessica also experienced the feeling of being watched, albeit to a lesser extent.

Gina the independent midwife whilst on her return to practice course, got into trouble for giving a mother pulsatilla to give to her baby, but even after this experience felt able to continue to make recommendations to mothers. A possible reason for this is that Gina, unlike the other midwives, had learned her acupuncture and homeopathy prior to becoming a midwife and felt very confident in their use. She had already decided to become an independent midwife homeopath and was

completing the return to practice course had been done for the sole reason of obtaining NMC registration.

*'When I was doing my return to practice I got into trouble for giving a mother pulsatilla to give to her baby, so the only way I would use it was to say to a mother if you got some Nux Vomica it would be really good for your heartburn and just recommend some acute remedies to them' Gina (43-46)*

Even though some midwives did not consider they were overtly '*being watched*' they were still unable to officially incorporate homeopathy into their practice. Chloe stated that '*alternative therapies were a definite No, No*' (56-57). This position was reiterated by Jessica who said when asked about using homeopathy:

*'No, not as a midwife, no you couldn't. because we were not to promote any other alternative practices because that wasn't advocated by the hospital, that was a strict no-no, you wouldn't say to somebody 'have you thought about having acupuncture or homeopathy or any other' (86-89).*

The midwives, who eventually chose to leave midwifery practice, chose to make recommendations to mothers about alternative approaches. This was done covertly. Chloe said that she '*was naughty, and .. would send patients to the homeopaths*' (57-59). Jessica believed that when it was in the best interests of the mother she was happy to refer to other complementary practitioners. She stated how:

*'I have said for people to go to practitioners, for example for a really bad back I would advise them to go to an osteopath rather than just say we can't do anything for you we will send you to the physiotherapist, but you have got a 6 week wait and in the meantime take these very strong painkillers, which they are worried about the side effects for the baby' Jessica (135-139).*

Grace described how as a community midwife:

*there was a lot of education going on and you could say take a bit of arnica but really I wasn't allowed to (120-121).*

Apart from Gina, who had trained as a homeopath prior to her midwifery, Emily during the time she worked in a GP practice where the GP was also a homeopath, and Jessica, the other midwives generally felt compelled to keep the two practices separate, often because they felt they had no choice. Grace felt that she *'had to keep it separate as (she) would have been disciplined'* (132).

Zoe, Emily and Grace said how they felt that it was essential to maintain professional boundaries as a midwife, and this meant separating the two disciplines. Zoe talked of the temptation to prescribe remedies to patients especially when they had brought a kit with them:

*'I think that comes really with a lot of it with what you can and can't do. A lot of people come into our hospital with their kits and I think I really want to tell them how to use this kit, because they are not particularly using it that well, and I want to tell them how to do it, but while I am working as a midwife I have to have my boundaries in place and whilst I can suggest 'have you thought about reading that one, it is difficult' Zoe (103-109)*

Emily described how she:

*'still occasionally get people who phone up who say I have been given your name, can you talk to me, and I am always very clear that I am talking to them as a friend who is a homeopath rather than as a midwife and signpost them then to where they can get the help, but it puts me in quite a difficult situation sometimes' (109-112).*

Grace said:

*I suppose I had to keep midwifery and homeopathy very separate because as a community midwife in particular you are delivering holistic care, more so than if you were in a hospital setting. So I was a community midwife and*

*predominantly we had to go in and do different things, but it was a bit frustrating I would say, because I knew and could see that a lot could be done but my hands were tied so other than saying perhaps go to parentcraft classes and things like that (114-119).*

Some of the midwives in the study observed that the medical hierarchy remained very evident in the hospitals. They felt this impacted on the way they were able to carry out their role and provide advice to mothers. Jessica described its effects, saying that it was not unusual for a doctor to intrude when she was with a patient and she felt unable to stop it. She described how a doctor would knock at the door during the consultation to:

*'say they want to come in as well, and then people see them as some sort of Gods so they don't want then to say anything at all and they wait till they have gone again to say another few things to the midwife and by then they probably only have one and a half minutes left of a consultation that they could well have benefitted from an hour to help them along the process of understanding their own body' Jessica (116-121).*

She believed that this interference, with its impact on both her and the patient, stopped her helping mothers to understand the things that were happening to them in the pregnancy. Had this not been a regular occurrence she considers that she would have been able to help mothers in a better understanding of their bodies and consequently understand what was happening to them. The impact of this medical hierarchy was deeply felt by some of the participants. This is despite the midwife being the specialist in normal birth. Jessica found that:

*'some of them (obstetricians) are really good, and the younger ones certainly...however, there is still that 'I'm the boss' attitude there. They still like to come and stick their beak in; they will still be there at the 9am ward round. There are odd times when they want to stick their nose in and have a look. It should only ever be high-risk women that see them in the first place' (245-250).*

Gina felt similarly stating that:

*'in the hospital system the medics still rule what the midwives do' (95).*

### **6.5.3 'Hiding'**

Whilst at first the midwives shared their delight at learning homeopathy over time this response became more muted. Chloe revealed that:

*'during (my) homeopathy training (I) wanted to have a round table talk about homeopathy, was always on (my) soapbox – learned to speak only when needed' (140-142).*

Emily said that as time has gone on few people know that she is a homeopath.

Occasionally, she still received referrals, but she was very clear that she provides the advice as a friend who is a midwife rather than as a midwife. She felt that this type of situation put her *'in quite a difficult situation'* (112), and preferred to keep any knowledge about her homeopathy under wraps.

### **6.5.4 'Struggle'**

The theme of 'struggle' came about as it reflects the story about the butterfly that cannot fly. The story tells of a man who on seeing the butterfly struggle to emerge from his cocoon, tries to help it by cutting the cocoon. He learns that the struggle helps the emergent butterfly, by training it and strengthening its wings (Coelho 2007). I used this metaphor in the study believing that it explains the struggles experienced by the midwives, and how these shaped and influenced the choices they subsequently made.

A part of this struggle was feeling that they needed to hide a significant portion of who they had become, and this had a significant effect on some of the midwives. This led some of them to changing jobs as they felt they could no longer reconcile homeopathic philosophy with the demands of being an NHS midwife. Grace said that she:

*'had been to college one Sunday and I came back and it was just something that clicked during that day, and I just thought 'you know what I am going to leave' and obviously we needed the income and all the rest of it and I just thought 'No! I am going to go' and went home and discussed it with my husband who was very supportive, and just said do what you have to, because I also had a nursing qualification I was doing a night every fortnight to help fund the homeopathy but thought I would do just a few extra shifts and that was my plan which I did for a little while' (194-201).*

Chloe chose a similar route, stating that she:

*'gave up (her) job, and went to work as a night sister in a nursing home' (60-61).*

She did this she said because she worked with a patient group who wanted:

*'massive vaccinations, and (she) found it harder and harder to do, ethically (she) couldn't continue as (she) disagreed with the policy. (She) had no way of incorporating my views into practice' (51-54).*

For Grace the decision to leave the NHS as a midwife came about when she experienced what she described as a '*vision*', after which she knew that she would be unable to continue in the role of midwife. What she was being asked to do was completely at odds with her values and the way that now felt. She described this as:

*'final, final, final nail in the coffin came when ...in a home of a first time mum and she was breastfeeding... I was giving the spiel and showing her what to do, and whilst I was talking I had a very, very powerful vision and I knew then at that point I would go' Grace (201-204).*

Jessica gave up midwifery to allow more time for her homeopathy studies as she believed that the hospital would be unsympathetic to her request to book time off for study and clinic attendance. When she had asked for a career break they told her that they were not happy to let her have the time off. She said that she:

*'wouldn't go back, ..couldn't, ... wouldn't want to, wouldn't say I couldn't, wouldn't want to look after women and give them conventional treatment, drugs, things like that when I know how much better it could be for them using homeopathy, and then I just wouldn't be able to use that at all'* (98-101).

The struggles experienced by the midwives were exacerbated when they tried to develop CAM policies within their Trusts. Emily recounts how every time the group she belonged to attempted to change the policies on CAM *'it kept on being blocked higher up and it wasn't just homeopathy, but every complementary therapy was blocked in our trust'* (66-69). Zoe experienced a similar difficulty, however in her case *'we got as far as pharmacy and it was stopped'* (166-169).

Sometimes the opposition came from within the ranks of fellow midwives. Grace tells of one incident where her manager rang her up early one morning asking her to go into her office immediately over *'something you have prescribed'*, Grace describes feeling that her *'heart stopped! Thinking 'Oh my God!'* even though she knew that it would not have been much as there was no holistics policy in place allowing her to prescribe. The midwifery manager would not tell Grace any more until she was in the office where it was revealed that a fellow midwife had reported her for writing *'chamomile tea'* on a piece of paper as a recommendation for a patient.

The reasons given for not allowing complementary therapies within the service were wide spread covering '*all sorts of reasons*' Emily (71). However some of the issues included the potential liability of Trusts, as well as the lack of an evidence base.

Emily reported that they refused to:

*'Give us vicarious liability, they wouldn't cover us – end of...we got fed up banging our heads against a brick wall'* (78).

Jessica (205-206) related being told that the evidence was not sufficient because there were only a few research studies available and stated that:

*'They don't even let people use aromatherapy now...because even with the scavenger system they realise that some of the aromatherapy oils could be smelt in the other room'* (201-204).

#### **6.5.5 'Restricting my autonomy'**

Not being able to offer a treatment in line with their homeopathy training led the midwife homeopaths to consider whether they experienced autonomy as midwives.

Jessica in particular felt '*frustrated*' (105) with the situation saying that things are:

*'more towards keeping everything on the right side of what should be done, rather than what is the best approach for the women, what she wants, so although we are standing up for the rights of women and what she might want for herself, always at the back of your mind is the fact that hospital policy says this, this, this and this. Because those that go down the route of what the woman wants and it goes wrong (will find that) there will be no one standing behind you to say I understand why you did that'* (-190). She goes on to say that she always '*felt quite autonomous as a midwife, but the autonomy is governed by the rules and regulations as does any practice, but to a far greater degree in midwifery*' (213-214).



Grace believed that this type of situation resulted in:

*'everyone doing what is perceived (to be) the right thing' in the 'right way' in the 'right order' because if they don't they are going to get slated and it is also the fear around litigation and they are all terrified'* Grace (230-231).

This fear of *'doing the wrong thing'* was widespread amongst the participants. There was also a fear of litigation and the feeling that no one would support them should they have failed to follow strict protocols. For Zoe this means that she only considered midwives to be autonomous within the boundaries of her Trust's policies. She explains how:

*'we are autonomous practitioners so long as we follow guidelines in the CNST. It is really prescriptive. We really do have to follow what is said, we can say, we haven't followed this because and then give a reason. Where we haven't followed a guideline you have to have enough reason to stand up in a court of law and say well this is what I have done.'* (38-42).

Jessica believes that her 'autonomy' is restricted by the medical profession. She stated that:

*'I realise you did have some autonomy, you could to a certain extent push the rights of women and what you felt was right for the women, there were always a lot of constraints, and at the end of the day if the medical profession felt that whatever it was that you had decided wasn't the right thing then that wouldn't be getting done'* (240-243).

The midwives in the study also spoke about the impact of the medical model on their ability to be autonomous. Grace said that she felt that her autonomy and that of the women in her care had been eroded. She said that:

*"they say we are autonomous, but also that the woman is supposed to have free choice and supposed to be in charge of her own body and birthing process and she is not, we used to teach that as community midwives and empower them to go into hospital and have it completely stripped away, they became completely overridden by the medical model. As soon as they were in that environment, they had a monitor strapped on you and if you weren't*

*progressing within the 4 hours or the 6 hours whatever, then they would start to intervene' (181-188).*

Chloe echoed this and said that:

*'On the surface mothers appear to be given a choice, however because of controls, the choice is not there any more' (114-115).*

Emily also found that her ability to be autonomous was constrained both by the limited time she had available, but also owing to a lack of funding. She stated that she was:

*'not able to offer the care that I want as a midwife, I haven't got the time to do that, the choices are limited' (211-212), but also that 'it is a women's choice out of what is available, that's the NHS we have at the moment. Money is making those decisions about what is available. I am sure that is why we have gone down the risk pathways because it is looking about putting more women into the community...this is good for the women ...I am not sure though that's what's driving it' (202-204).*

#### **6.5.6 'Adapting'**

The midwives were able to find some solutions and workarounds to enable them to adapt to the situation they found themselves in. As already mentioned, a few ignored policies and continued to advise women about alternative approaches but this was not widespread practice. Those midwives who felt and behaved this way did eventually leave NHS midwifery. As already discussed, the midwives who remained in the NHS were acutely aware of maintaining what they considered appropriate boundaries, and did not prescribe homeopathic remedies to patients.

Emily considered herself fortunate to find work with a GP homeopath that was able to sign off prescriptions on her behalf. In this way she was able, for a short time, to offer homeopathy to the women in her care. She said that:

*'the GP I worked with was actually a homeopath who knew the homeopathic set up locally, so he was quite happy for me to practise homeopathy under his umbrella effectively, and I could tell patients what I wanted and he would write scripts for me and they would get it on the NHS' (24-27).*

Zoe, with the permission of her manager, found her own solution to not being able to prescribe remedies to patients. She stated that:

*'the midwives used to refer to me in my private clinic,... and the guidelines said that a midwife could support a woman's choice as long as she was independently insured and a registered practitioner (26-29).*

## **6.6 'From Cocoon to Butterfly'**

This section explores the midwives stories as they emerge from their '*cocooning*'.

The cocooning was a period of change and reflection from which the midwives emerged as midwife homeopaths. However, as discussed, in order to achieve congruence between their beliefs, values and practice, three of the midwives determined that instead of being a midwife homeopath they wanted to take up homeopathy practice on a full time basis. This meant that of the six participants, one chose to work as an independent midwife, two midwives continued their midwifery practice, and the remaining three chose to leave midwifery and become full time homeopaths. All the midwives continued to practise homeopathy in the private sector.

The following section explores the views of the midwives on combining homeopathy and midwifery. I then turn to an examination of the stories told by those midwives who remained in the NHS. They discuss the ways in which homeopathy has contributed to their practice. I conclude the chapter by describing their views on the future of CAM in midwifery.

### 6.6.1 Homeopathy and midwifery

The midwives discussed their views about the use of homeopathy in maternity care. Emily described the GP she worked for as *'extremely holistic'* (27), and says that he *'was a big advocate of home births and we did a lot of home births and homeopathy was just another thing incorporated into the practice'* (29-31). When reflecting on working in the practice she notes that:

*'we were looking at setting up a trial for caulophyllum for induction of labour and we were very proud of the fact that we had never had to have anybody induced, so for me it worked incredibly well' (61-63)...'.we were really proud that we didn't have to have women go through the induction process, we got them into labour' (195-196).*

Emily was particularly proud of the contribution she made in enabling women to have successful home birth experiences. She recalled how:

*'we had very successful home births that were very straightforward and very few transfers in' (64-65).*

However, when Emily's GP employer retired, so did the provision of homeopathy at the practice. The surgery was restructured and Emily was moved elsewhere, saying that the *'wind came out of the sails for it'* (88-89).

Originally, Emily's dream had been to run a homeopathy antenatal clinic so that she could:

*'treat some of the things, or support some of the ladies through what they were going through, it would have given them better outcomes. You know we induce between six and ten women a day, you know caulophyllum for them would make a huge difference to the workload, to the women's experience, length of stay, intervention (190-194).*

Jessica believed that the use of homeopathy would have enabled her to give time to clients, and to help them take a more active role in their health, noting that this is

*'the absolute perfection of homeopathy, that you can give time to your clients, to give them the chance to approach their health. So that things click for them and they think 'yes, I have just told you my story but now I am realising myself where some of these problems come from...'* (105-108).

She would have liked to have seen the introduction of a more holistic service for women, one that included not just homeopathy but also:

*'a natural birthing unit in the area....but that has gone by the wayside for funding reasons for now...and I think I would like to see just an integration of a more holistic approach'* (194-196).

Jessica considered that in:

*'an ideal world if we had everybody on constitutional treatment before they were ever pregnant then you see ideally we would just float through...with a few therapeutics as they go along. Things could be an awful lot better. If you could integrate both it would be fantastic'* (240).

Gina, working as an independent midwife, echoed Jessica's comments. She believed that homeopathy could be integrated very successfully into maternity care, and thought that:

*'homeopathy is fantastic in pregnancy and birth, I mean you can never guarantee it because you don't know what would have happened if you hadn't given it, but so many times I have seen women that just seem to be stuck, [and then] move on in an acute setting after homeopathy, and I think that if you are in the position to treat them constitutionally that is even better during their pregnancy'* (66-71).

The midwives who left the NHS, tended not to specialise in the treatment of pregnant women, but instead saw them as part of a mixed practice. Grace says that she had a *'mixed case load, 'with some couples with infertility stuff'*, and she *'also treats women antenatally for their pregnancy symptoms'*. She reports that she

had not *'actually gone into the birth'* instead she *'give(s) them a little pack to take in with them for labour and afterwards'* (242-245).

### 6.6.2 'It's the way that you practise'

The participants who remained as NHS midwives reflected on their practice. As an example, Zoe, who although unable to prescribe homeopathic remedies as a midwife, believed that *'you don't need to give up midwifery'* (97-98). She explained her belief that:

*'homeopathy is not just about the remedies but about the way that (she) practice(s)'* (284).

She stated that in her opinion:

*'you can practice midwifery holistically, you can do that, and that is where you become a practitioner in your own right, because you can support people in a holistic way and follow guidelines and protocols'* Zoe (93-95).

In contrast to Zoe's views, Emily felt unable to offer the care she wanted to as a midwife because she had not:

*'got the time to do that, the choices are limited, the clientele that I now care for are of a low socio-economic, mainly white group who are to a large part on benefits who are not interested in that....and I as a midwife are bound by the trust that I work for and can't encourage them to use paid for services, and you don't want to put them in the position of having to pay for services – that is unethical. They can only have what is available'* (211-218).

She expands this by saying how she has:

*'learned to live with it and I have had long enough now to learn to live with it, because that's the service I'm working in, I have to tow the party line, they pay my wages, if I want to stay there and do it, that's the line I have to take'* (219-221).

However, notwithstanding this, Emily felt that it was still possible to *'care for (women) in a holistic way'* (221-222). What is of particular note however, is that unlike Zoe, Emily had previously had the opportunity to work within the NHS as a midwife homeopath and was now unable to offer the same care she had. This will undoubtedly have had an effect on how she viewed her current practice and the lack of opportunity to practice homeopathy.

Zoe provided examples of the care that she was able to offer. She offered this story as an example of how she considers herself to have become a *'practitioner in her own right'*. This practitioner is part midwife and part homeopath, and results in her support of mothers and their families in a holistic way whilst still following guidelines and protocols. She said that:

*'everything I learned in my homeopathy training and practice benefits my midwifery. I think that what I learned as a homeopath and in my training, one of the big things I learned was to listen'* (202-204). She continued with noting that *'the other thing that I think is fantastic about the training I did as a homeopath is I am much more alert to when somebody has something that they need to tell you and that really, really helps to know when people need to talk and people do open up and talk to me perhaps more than they talk to other people'* (209-212).

Zoe's first example concerned a young girl who was admitted to the midwifery led unit from the consultant unit. She was post mature, and went into labour spontaneously so did not require induction. The young girl brought along a birth partner and Zoe discussed the type of things she preferred and helped with the preparation of a birth plan. After going into the labour room Zoe said that:

*'we got the lights dim, got baby clothes out so she had something to focus on, trying to think what was going through my mind with her? She had quite*

*a problematic history really, but we looked at that, we did a lot of talking, allowed them to talk whenever they wanted. I went in only when I had to do what I had to, like listen to the baby, do her blood pressure, and stayed and chatted when she wanted to and relax when she didn't, and she progressed beautifully in labour and had a wonderful normal delivery with a baby that was actually quite ill, and why the baby was ill we don't really know, we know that the baby had some kind of infection for some reason, but we don't know where it came from, the baby and mum had to be transferred to a neonatal intensive care unit, but she came back to me ...brought the baby, brought us lots of gifts and goodies and they are doing a sponsored bike ride because even though the baby was ill she felt that the experience was fantastic, as what happened, the support, everything. The baby was fine' (99-117).*

Zoe believes that she provided holistic care within a difficult situation. In this situation Zoe was acutely aware of the couple's needs. She was paying attention not only to the physiological condition of the mother, but also actively listened. This was an example of the holistic care offered by Zoe.

Zoe went on to describe another example recounting that the unit has:

*'quite a lot of young girls that are pregnant and a lot of social deprivation and when people are coming in early labour and very upset and not coping you can do things like pull out sofa beds and allow the partner and them to be together, and put the lights out and just say if they are in early labour, ring me if you need me, but they are under the umbrella of them feeling safe. You can move your practice in those sorts of ways that is not a problem' (120-125).*

The third incident concerned a lady who could not speak English. Zoe described how:

*'they were wanting to do lots of things with her and I said, WHOA! You can't do that, we have to find some way of getting her to understand what you are trying to do to her and get her consent, you just can't go in and do what you want. So from that point of view I think I still do look at people in a very holistic way, which I always did to a degree, but not to the degree that I did after my homeopathy training' Zoe (213-219).*



Zoe was aware of her values and was willing to challenge practice that she felt was unsatisfactory.

Zoe was not alone in believing that homeopathy had made a positive contribution to her midwifery practice. Emily had also noticed a change in her views surrounding health and well-being. Emily now reported that through her homeopathy training she now perceives that health:

*'It is about looking at the whole person, (homeopathy) has really reinforced the whole low risk, normal, listening to your body, nature understands and tap into that first. It made very clear to me the fears issues. I have seen that so many times in play of ladies who are fearful and if you can overcome that not necessarily by homeopathy but by other things then you can make a huge difference to their outcomes' (114-118).*

Emily expanded on her views about fear. She said that:

*'It depends what the fears are, and depends on what they perceive are their fears because it may be that they do not recognise they have got a fear. So mainly it would be talking to them and advising them where they might get the help that they need either conventionally through the medical route or to go out and explore other fields including homeopathy that might help them' (121-124).*

Like Zoe, Emily still views herself as a homeopath as well as a midwife. She notes how:

*'Every woman that I book still has their case taken (homeopathy) and that has been commented on by students about the way that I can follow a case. Perhaps you won't have seen the antenatal notes we use, there are an awful lot of tick boxes in it with space to write beside it. I know my way around the notes but because I can take the case and interact with the woman I can dot about in the notes and get the information, and I tend to have less of coming back later and saying 'I forgot to tell you' because as they are talking I don't interrupt them to go back to the next tick box and it doesn't get forgotten about. So I think the case taking skills have made a big difference' (126-132).*

Both Emily and Zoe felt that the homeopathy had enhanced their skills. Emily believed that:

*'no learning is ever wasted so what I bring in from homeopathy is always going to be part of me, so I am always going to use it but I don't see it as being separate and different, it is all integral to me so one builds on the other and one enhances the other' (139-142).* Emily remained pleased that she embarked on training as a homeopathy, and said that *'I don't regret doing the homeopathy training, I have learned such a lot both personally and to add to my knowledge of people that I can then go on and use in my job' (142-144).*

Zoe considered that an important aspect of her job was to ensure that couples felt safe and secure. To do this she not only thought about the mothers needs, but also about their needs as a couple. Of this, she said that she didn't know:

*'if I would have had that feeling before I had actually practised or trained as a homeopath, and so this person is asking me for something special, and that they have needs here, and when those needs are met then they are going to relax and get on with their labour' (231-235).*

### **6.6.3 'Putting something back'**

Neither Zoe nor Emily were prepared to leave midwifery. Zoe said that she continued practicing midwifery as she believed that she had something unique to contribute. Significantly she considered that she had a role as an advocate for the mother and family. Emily believed that caring for mothers and their families in a 'holistic way' (222) was important.

It was apparent that the midwives who had stayed in the NHS had come to terms with their role. Zoe said that she had become more comfortable *'work(ing) within the system'* (225) whilst Emily said that she had *'learned to live with it'* (219).

Although not able to change practice to enable homeopathy to be used in their Trusts, neither Emily nor Zoe have given up trying to influence health policy. Emily has recently moved into a management role within the trust and stated that she was attempting to *'formulate trust policy across the board looking at all the things that we're looking at, trying to write policies in a more holistic way'* (228-320). Whilst this is not about the introduction of homeopathy into the trust it is about taking the values and principles developed by studying homeopathy and adapting them to fit into the care they offer within their maternity service. Emily says that:

*'all this has made me want to make change and I particularly want to be making the change, not having change done to me where I have no influence over it....I like to think that I come from that person centred place....it is bringing all that forward so that voice is heard'* (236-241).

Zoe stated that she is a member of a clinical risk team in a Trust that had been under review and felt that this experience led to staff working very defensively to the detriment of the women in their care. Her message as part of this team was to try to get staff in the trust not to adopt this way of working. She says that they were trying to put policies in place to stop unnecessary intervention. Zoe wanted to introduce policy that supported midwives so that:

*'they don't feel that they have to justify not doing a procedure, and so I feel we are trying to build up confidence ...and give them the back-up'* Zoe (272-274). She observed that *'people had become very defensive and so have lost that feeling of interacting and writing in stuff that doesn't matter'* (281-282).

Zoe gives an example of a situation where she feels that the values she learned through her homeopathy training show through. It demonstrates a real feeling of supporting not only a normal birth wherever possible but also working with the family.

She recalled that she:

*'had one lady ...that was using a homeopathy kit and I did try to advise them as much as I could through it, but she had a real mental block there, but when I worked with her and her partner we worked within the realms of what was considered to be safe, but we got on board the registrar because she said just give me a little bit longer to see if I can do it, and you know he was absolutely fantastic actually, because we did break the barriers of all the protocols and documented everything such as; 'this is a request, the baby was absolutely fine and everything was ok and went with her wishes and of course that can always be done, they are the things I do to try to work with somebody's express wish' (285-295).*

## **6.7 Discussion**

In this chapter I explored the midwives experiences during their homeopathy training and the impact this had on their practice of midwifery. A way of structuring these experiences is to separate them into meaningful chunks or units. Polkinghorne (1988) believes that people without narratives do not exist, and for Moen (2006) the whole of our lives are a narrative of many stories. Narratives are an important element of living; they allow humans to construct meaning around their experiences (Polkinghorne 1988). Thus, by providing the midwife homeopaths with a space and opportunity, they were able to revisit their own stories and reflect on who they once were and who they had become.

The metaphor of 'metamorphosis' goes some way to reveal the remarkable transformation they underwent during this period. Before embarking on their homeopathy education the majority of the midwives were blissfully embedded within a conventional paradigm. They were largely unaware of alternative paradigms, and

they had mostly grown up and trained within an orthodox model of healthcare, and were content providing this style of care to others. Gina was the exception to this, having perceived a lack of the effectiveness of conventional medicine at an early age. This would appear to be a more unusual route, and whilst I am aware of instances where homeopaths have gone on to study podiatry, nursing and medicine, this information is not formally captured by either CAM or the allied health, medical or nursing associations.

The remaining midwives only became interested in alternatives with the advent of their own or family members illness. It was this event that enabled them to be receptive to homeopathy. A study by Doherty (2010) found that people chose to become midwives for a plethora of reasons including: their own or a member of their family or friends birth experiences, a love of caring for women and their babies, seeing midwifery as a vocation, being encouraged by others or having experienced what they describe as an epiphany. What is particularly striking is that any of these reasons for becoming a midwife could be substituted as reasons why midwives choose to become homeopaths. Whilst the midwives in this study initially chose to become homeopaths because of issues with health or healthcare, they also mention the other factors, such as seeing homeopathy as a '*vocation*', or their own '*homeopathy epiphany*'. The School of Homeopathy found similar reasons to exist within their own cohorts of homeopathy students (2013) writing that people decide to train in homeopathy because they may have '*unanswered questions about their life, (or) fancy a change in direction*'. For others it is said that it is their own positive experience with homeopathy that draws them into study or that they feel the philosophy and practice of homeopathy '*makes sense*'. Once attuned to the presence of an alternative paradigm they chose homeopathy because it '*fitted*' with their newly developing worldview. Miller and West (1993), researched the world

views of people belonging to five professional groups – social scientists, physical scientists, lawyers, military personnel and priests. They found their worldview categorisations were in the main congruent with their choices of career. Miller and West (1993, p.3) described how *'one's choice of career must, to some extent, reflect one's philosophical orientation and one's fundamental assumptions regarding the sources of basic truths and proper goals of life'*.

This suggests that midwives select their homeopathy training because they perceive it to be consistent with their own worldview. Were the training experiences to differ significantly away from this then they would either adapt their world view, adapt what they learn to fit their existing world view or refuse to engage with those subject that challenge this view.

Once the midwives had decided to train as homeopaths they became voracious consumers of all things homeopathy, as well as being passionate advocates for its practice. During this time of immense change to their worldview, the dynamics between them and the world around them changed, and they no longer related to the world in the same way as previously. At first they were vocal about their newfound passion, however owing to the reception they received they became subdued about letting colleagues know that they were also homeopaths.

I now want to turn to Tina, a midwife homeopath who was interviewed as part of the study, but shortly after contacted me to say she wished to withdraw. She felt that it might be possible for others to identify her from the information she provided during her interview. Tina had been very candid about her experiences and had gone

away and thought about the implications for her should she be identified. Tina had been critical about the unit she worked in, and she believed that knowledge of this could cause tension on the unit. In addition, only close friends and colleagues in the unit knew that she also practised as a homeopath, and on reflection she felt this separation between the role of midwife and homeopath was important to her. This ties in with the experience of the other participants as discussed earlier, and Tina expressed concern that colleagues might view her differently if they knew that she was a homeopath. However, she was keen to stress that she did not hide the fact she was a homeopath, but she did not promote it either. This practice is similar to that of both Zoe and Emily. Emily shared this reticence saying that no-one at work knew she was a homeopath and that she kept the two practices separate. Zoe was less secretive and said that everyone at work knew she was also a homeopath, however despite considerable temptation to the contrary, she was very careful to maintain her professional boundaries.

## **6.8 Conclusion**

By reflecting on their transition from midwife to midwife homeopath, and homeopath to midwife homeopath, the participants were able to share the impact this had on their personal and professional lives. They were able to articulate some of the many issues faced by them, but also some of the more positive experiences as well. Each story is unique to the midwife narrator; however taken together their stories demonstrate a compelling picture of their attempts to achieve personal authenticity in a system that does not appear to value it.

Chapter seven entitled '*Returning to Heidegger*' discusses the findings through a directly phenomenological lens. I use Heideggerian concepts to reflect the midwives experiences as they underwent their transformations.



## Chapter Seven: Returning to Heidegger

### 7.1 Introduction

The previous chapter considered the midwives narratives, framing them through the metaphor of '*metamorphosis*'. The type of change that occurs during a metamorphosis was a way of conceptualising their experiences.

Engaging with the data led to my interpretation of the midwives attempts '*to be*' themselves. The picture shown by them included stories of struggle and challenge before they eventually emerged, able to choose the path that enabled them to live in a manner that was congruent with their values and beliefs. This led me once again to the philosophy of Heidegger, and the notion of authenticity. An authentic life is one lived with integrity, where the midwives dictate their own life-stories. To be authentic a person does not simply '*occupy*' a role, but choose it resolutely, adopting a particular way of '*being in the world*' (Stanford Encyclopaedia of Philosophy 2010). In contrast, inauthenticity, Heidegger says is '*fleeing in the face of my Being and forgetting that I can choose and win myself*' (Heidegger 1962: 69-70). Authenticity and inauthenticity are the means by which Dasein chooses their own possibilities (Heidegger 1962: 78).

In this chapter I propose to analyse the midwives narratives in the light of their mode of existence and how this changes as they metamorphose into midwife homeopaths. I returned to Heidegger after considering a range of possible theoretical lenses for the synthesis of the findings. I found that many of his metaphors helped to explain the midwives stories. The alternative perspectives are discussed in Appendix 1 (p.326) entitled '*My reflections on the study*'.

The key Heideggerian (1962) concepts of '*Becoming*', '*Mood*', '*Understanding*', '*The Call*' and '*The Clearing*' are used to structure this synthesis.

### 7.1.1 '**Becoming**'

*The perfection of human being-becoming what one can be in being free for one's own most possibilities* (Heidegger 1962:199)

This section explores the concept of the midwives 'becoming' from a Heideggerian perspective. I propose to examine this transformation and critically analyse how '*being authentic*' has guided them as they made decisions, before exploring the implications of those choices on their personal and professional lives.

All the midwives believed that becoming homeopaths had been a positive experience for them. Those who stayed as midwives felt that homeopathy had significantly enhanced the way they are able to care for women. This provides insight into how the midwives came to understand and interpret their world and achieve an authentic way of Being. It is the authenticity of the midwives that allows them to make use of the values and skills they developed whilst training as homeopaths into caring for women.

Choosing to become a midwife homeopath is not a straightforward decision, nor is it one that naturally follows on from being a midwife. Being a homeopath in the 21<sup>st</sup> century is not easy. Although there is some NHS provision of homeopathy (chapter two) there is little in the way of institutional support, and derision and ridicule is often heaped on those who do choose this path, whether as a patient or practitioner (Goldacre 2007).

During their interviews the midwives say that they were content before discovering homeopathy, and felt part of a maternity services community helping each other and the women they cared for. Generally they enjoyed their work and for most of the participants it was a place they loved to be.

For Heidegger, the notion of authenticity did not include 'genuineness' or 'being real' in a humanistic sense (Donaghy 2002). Instead he attributed an existential meaning to it, of 'existing according to one's essence' (Heidegger 1962: 247-277). Heidegger was not alone in his exploration of what it means to be authentic; it also occupied the minds of philosophers and psychologists including Maslow (1968), Kirkegaard (1985), Sartre (1992) and more recently Tillich (2000). From the data obtained, I believe that it was not possible to establish the state of authenticity prior to the events that transpired other than their expression of contentment. As each individual has a unique perspective it is conceivable that the midwives could have been authentic *or* inauthentic as midwives. It is possible that the midwives were able to move from one authentic position to another, once new information became available to them. If they had remained doing things exactly the same way when their thinking had changed they would have become inauthentic. Steiner and Reisinger (2006) claim authenticity is a state that, because it is experience dependent, can change from moment to moment. Thus they argue authenticity is both transient and non-enduring. Kirkegaard (1985) wrote that being authentic requires that a person chooses to live in accordance with their own identified sense of self, whilst Sartre requires that a person assert their own will when confronted by possibilities (Sartre 1992). Sartre considered that to experience an authentic life individuals must create their own meaning in their lives. In itself, he believed that reality is meaningless. Maslow (1968) and Heidegger (1962) both considered that a person could choose to be authentic by paying close attention to their own experience instead of interpreting the world through the gaze of others.

To explore what it means to be authentic, Heidegger concerned himself with the ontological question of '*being*', which he called Dasein, translated from the German as '*being there*' or '*existence*'. It is this Dasein that became the subject of his text '*Being and Time*' (1962). Dasein can be used to mean either '*being in the world*' or as a way of describing a '*human being*' (Diekelman 2005). Polt (1999, p.43) deems it to mean a person '*whose Being is existence*', and it is in the nature of this '*Being*' or '*Dasein*' to live authentically or inauthentically.

In their '*run of the mill*' world the midwives were caught up in the everydayness (fallenness) of their lives, leading to their existence as socialised beings in their workplace. Each midwife had a choice whether to get caught up in and remain part of the '*They*,' which is both everyone and no one, or they could choose to be authentic. Harman (2007) states that without authenticity, inauthenticity could not exist (Harman 2007). To be authentic there has to be something to move away from. The midwives, in moving away from their previous understanding and ways of managing health and illness, were starting to think for themselves and start to '*either truly come to grips with (their) own deepest possibility of being, or draw (their) ambitions and self-understanding from what the public says*' (Harman 2007, p.60). Had they continued to respond in the same manner they would have chosen to live an inauthentic life. Once the participants started to question things previously unquestioned, and became '*concerned*' in the world, the '*angst*' experienced indicated their adoption of a more authentic position. Their authentic existence came to fruition when the midwives finally realised who they truly were and understood that each human being is a distinctive entity (Gibbs 2010). Polt (1999) states that as human beings or Dasein each individual possesses a '*mine-ness*' or subjective presence, which leads to their being constantly occupied with their own '*being*' and '*being in the world*' and what that means to them. This also applies to the midwives in the study. To be in the world, they had to bring that world into being,

and develop a way of interacting with the world through smell, hearing and seeing. They experienced space and time in a certain way, and brought colour and sound to the world; a world that they allowed to exist through their presence in it (Bracken and Thomas 2005). They created their own world. Dreyfus (1991, p.10) argues that:

*'what Heidegger had in mind when he talks about Being is the intelligibility correlative with our everyday background practices'*

The midwife's sense of '*being*' was their momentary place in the world, the place illuminated by Dasein's projection, and if Dasein has a different centre then the way they responded would be different.

Macauley (1996, p.68) reports that Heidegger believed that the world exists as an interrelated network of '*meaningful reference relationships that constitute the pathways of one's existence*'. The connections in this network pre-exist the experience, they must always, already be there to be experienced. It is this interconnectedness that both makes the experience possible and allows meaning (Heidegger 1962: 59-105). This means that the possibility of homeopathy as a means to authenticity already existed in the world, and became a possibility for the midwives when it became illuminated. This illumination could only happen when the challenge caused by the ill health of their relative or self occurred. When this challenge happened, Grace, Emily and Chloe found conventional medicine had nothing to offer them that was not outweighed by the side effects of the treatment. For Chloe it was when her doctor wanted to put her daughter on steroid inhalers for asthma, whilst for Emily the challenge came when she took her baby to the doctor with an ear infection to be told that babies of three months '*don't get ear infections*' (Chloe 39).

As Dasein the midwives each had a subjective presence that led them as human beings to being constantly occupied by their own Being and what it meant to be in the world. This is called 'concern' or 'care' (Heidegger, 1962: 103) and when choosing to do something 'concern is a way of being'. Only a being whose Being is that of existence, the ability-to-be, or care, can be authentic. It is this that enables choices to be made from amongst the myriad of choices available. When choosing to take something on, or do something, we become 'concerned' as a way of being, and it is this concern that compels us as human beings to make decisions amongst the myriad of options open to us. For the midwives this concern overlay a mood as part of their facticity arising from them being thrown into the world, and it is this mood that allowed them to be susceptible or attuned in a specific way. It enabled them to look at things in a new way. Had their experience of ill health been dealt with sympathetically or effectively by the medical professionals then the possibility of homeopathy may not have revealed itself or had the opportunity to be illuminated. Grace says that she just:

*'thought I can't do this to my child, so at this point she had started school and I decided, just said to my husband at the time, I am going to find a homeopath, not really knowing what it was about, not knowing anything about anything really and just thought it is an alternative medicine' (Grace, 24-27).*

### **7.1.2 Mood (Befindlichkeit).**

'Mood' is neither an emotion nor a state of mind, instead a mood is the thing that allows things to matter, it is a pre-cognitive state. It is the underlying state that is 'grounded in one's attunement' (Heidegger 1962: 176). A mood is a necessary state to our 'thrownness' into the world (Heidegger 1962: 174). Grace's mood was revealed when she said:

*'I was in a home of a first time mum and she was breastfeeding and I was giving the spiel and showing her what to do and whilst I was talking I had a very, very powerful vision ... and knew then at that point that I would go and I was quite bored of the whole thing' (Grace, 202-205).*

The underlying '*mood*' of boredom allowed things to matter, hence what she called the vision. Boredom was both something that had '*befallen*' Grace as well as the '*attunement*' (Stampbaugh 1996) that enabled her to '*see*' homeopathy in her future.

Mood is reported as one of Heidegger's three existentials, alongside understanding and talk. The three are tightly integrated so can only be understood as a unit.

Heidegger stated that beneath '*concern*' or '*care*', there is a mood which '*assails*' us and which arises from being thrown into the world (Heidegger 1962: 174). It is moods that reveal our '*thrownness*' into the world. Heidegger wrote that the '*thrownness of Dasein ... reveals itself in attunement (mood) in various ways*' 1962: 252). Critchely (2009) explains that '*thrownness*' is the '*simple awareness that we always find ourselves, somewhere, namely delivered over to a world with which we are fascinated, a world that we share with others*'. Jessica described her '*thrownness*' into a medical world; she had been a midwife for 20 years and came from a '*whole medical background side of things, husband who is a medic and friends all medics*' (Jessica, 74-75). Being in a '*mood*' is essential to '*being-in-the-world*', and portrays our '*already having been in the world*' (Heidegger 1962: 396). Were we not to have a '*mood*' there would be no Dasein. It is a distinctively human way of having a world (Heidegger 1962: 173). Even when we think we do not possess a mood, we do, in the form of what could be described as an inconspicuous mood. A mood informs us about how things are, and how we sense ourselves to be in any situation, and whilst it is possible to *not* respond to the mood, if this happens there is another mood, and another and so on. Moods are part of our facticity or our having being thrown into the world. It is this mood or attunement that allows us to be open to the world in specific ways. It is about being open or susceptible to possibility. Things show up as mattering or being important in this mood (Befindlichkeit). Heidegger (1962: 134-135) noted:

*'In being in a mood....the pure 'that it' shows itself, the where-from and where-to remain in the dark....in everyday life the human does not 'give in' to moods, that is to say, does not go after their disclosing'*

Without responding to what the mood reveals a person cannot be authentic. Jessica said how she was perfectly content in that world until she was ill, and even though initially she *'did everything (she) was supposed to do'* she *'full well knew she wasn't getting any better because she realised she had to some something herself'* (Jessica, 8). This essentially means that the midwives are thrown as human beings into a pre-existing world. As *'Beings'* they experience moods that are part of their facticity. The mood they experience allows them to be open to the world and thus susceptible to the possibilities surrounding them. If they were not to respond to the mood and retreat into the *'They'* the midwives would be inauthentic and not be able to attain their possibilities. Stambaugh (1996) calls this mood an *'attunement'*, whilst Blattner (2006) calls it *'disposedness'* and Dreyfus (1991) *'affectedness'*.

### **7.1.3 Understanding (Verstehen)**

Understanding (verstehen) is the existential being of Daseins own potentiality for being. It is where we see something as *'Something'*, and also our *'capacity for practical action'*. Polt (1999, p.68) states that *'we disclose things by letting them be involved in a possibility of our own being'*. According to Gendlin (2013) even if we do not know there is a mood that assails us there is still an understanding that we are living in that mood. We are where we are because of our choices, and understanding is implicit and inherent in those choices. As we take on future possibilities, the way we understand who we are and what we are able to do makes future actions possible. In the process of reaching an understanding, we interpret or work out the possibilities projected in this



understanding (Heidegger, 1962). Consequently interpretation is a process that takes a practical interest in whatever is understood. Grace expressed boredom as an underlying mood, however that mood opened up the possibility of homeopathy to her, she explained how *'in a way the midwifery was an experience and a stepping stone into homeopathy, from nursing to a more natural model of healthcare, to homeopathy – so kind of a natural progression I suppose* (Grace, 259-261). By understanding her mood Grace was able to make an authentic or resolute choice.

Jessica explained that she realised that her health was not improving because she had to do something about her situation herself and said how she understood that this was *'part and parcel of how things were at work, and how dissatisfied everyone was, and just thought out of the blue one day that this was not for me anymore, and I am going to go and do homeopathy'* (Jessica, 9-11).

#### **7.1.4 'The They' (Das Man)**

For Heidegger each individual has its own Dasein. People are born into a world that consists of other Daseins. This means that the world is already full with a myriad of different ways of seeing things, of attitudes, beliefs and knowledge. Heidegger argued that it is difficult to be truly oneself (authentic) in the face of so many other Dasein. People are, he believes, shaped by the influence of other Dasein. For example Chloe says *'Think of the ignorance of people'* (Chloe, 134) referring to the *'They'* of society not recognising alternative paradigms of health, before going on to say that *'people are not being allowed to know about it (homeopathy) in general, not just midwives'* (Chloe, 134-135). Chloe is concerned that the *'they'* determines what is written in the media stating that *'we do not have free press in this country – negatives are written about, studies ignored'* (Chloe, 135-137). She believes that the *'they'* are influencing people

and determining (or restricting) the possibilities open to them. Heidegger said that *'in my ordinary, everyday being, I am not myself at all; I am the 'one''*. It takes a great effort of *'clearing away concealments and obscurities'* if I am to *'discover the world in my own way'* (Heidegger 1962: 129).

People exist as socialised beings, standing within the world, influenced by family, education and society. In conforming they become threatened with the loss of themselves, and in failing to be themselves they become part of the *'They'*. This is reflected in the midwives stories; they are expected to conform. Zoe noted that *'we really do have to follow what is said'* (Zoe, 39), and Grace stated that *'I knew and could see that a lot could be done but my hands were tied, so other than saying perhaps go to parent craft classes and things like that'* she could do nothing (Grace, 118-119). The *'They'* represent a strain or pull that may impact on their ability to be *'oneself'*, to be authentic. Heidegger stated that when we are being inauthentic, we take on the values of the *'They'*. Emily described how she had been *'in the conventional model at that point'* (Emily 42-43); she was a part of the *'They'*. In the same way, Jessica existed within a world made up of *'they' 'medics'*. Neither Emily or Jessica questioned their involvement as part of the *'They-world'*. Jessica realised that she had moved away from the *'They world'* when instead of supporting her, medics, some of whom were friends asked her *'what the hell are you doing!'* (Jessica, 75).

This *'They Society'* is both *'superficial'* and *'tranquilising'* (Heidegger 1962: 25-27). Wrathall (2005, p.55) wrote that it is in the nature of the midwives as Dasein to lose themselves in the everydayness of their existence:

*'we take pleasure and enjoy ourselves as they take pleasure; we read, see and judge about literature and art as they see and judge; likewise we shrink back*

*from the 'great mass' as they shrink back; we find shocking what they find shocking'.*

Heidegger described the 'They' as primordial and as being both outside and within each of us. It is our social existence. The 'They' is everyone and no one. Being authentic and being oneself is not detached from the 'They'. According to Harman (2007) Dasein worries constantly comparing their own Dasein to that of other Daseins. We can choose to take up the possibilities of the 'They' self and remain inauthentic or we can take up a more authentic understanding. Grace (77-80) recalled the instance when she felt she was no longer a part of the 'They'. She said that:

*'on the last Friday, I distinctly remember waking up and thinking, hold on a minute, they can tell me what sock to wear, they can tell me what I can do and where I have to work in a seven and a half hour period when I am there, but they cannot tell me what I can put in my body'.*

This was her response to the 'they' trust telling her that she had to be immunised against Hepatitis B when it was contrary to her burgeoning beliefs about health and healthcare. The midwives still live and relate to the 'They', but are qualitatively different in the ways their thinking has moved.

Sartre (1905-1980), a student of Heidegger, added his own understanding of authentic existence, writing in his essay titled '*Existentialism is a Humanism*' (1989) that man is first and foremost an existing being, and that he has no predetermined '*human nature*'. We remain completely free to create our own nature, and as such we are both a never-completed work and one that is projected in time towards the future. When determining who we are, we can, in the same way as Grace, choose to act authentically with honesty and integrity, or inauthentically when we forget our freedom and stay rooted in pre-existing patterns. Acting authentically is when we self-create ourselves within the

context of our fundamental freedoms. The question then becomes centred on the difficulty of being authentic in a sea of inauthenticity. For some midwives in the study, this meant leaving the NHS. Jessica (105-108) explained how she was not prepared to do it any more, saying:

*'I wouldn't go back. I couldn't, I wouldn't want to , wouldn't say I couldn't, wouldn't want to look after women and give them conventional treatment, drugs things like that when I know how much better it could be for them using homeopathy, and then I just wouldn't be able to use that at all'.*

Jessica's story shows the real conflict that she experienced between being authentic or inauthentic. She could have remained as a NHS midwife but not been allowed to use homeopathy, or she could choose to leave and live what was for her an authentic life.

Harman (2007) suggested that one way that Dasein might become authentic is in its relationship to death. Dasein exists within time or temporality as Heidegger termed it, and temporality needs to be explored within the context of '*being towards death*'. As human beings we exist between birth and death and are shaped by time. For Heidegger, time was a threefold condition, but not a linear replication of the past present and future. Critchley (2009) explains that the popular conception of time against which Heidegger rails is largely Aristotelean with a future which is the '*not-yet-now*', the past which is a no-longer-now, and the present as the bridge that allows the flow from the past to the future at any passing moment. Heidegger purported that in '*being-towards-death*', the future is revealed, and so the human being is always projected towards the future, but what comes of the future is part of the past, with all its attendant trappings (Critchley 2009). This is what Heidegger calls a persons '*having-been-ness*'. This does not mean though that these trappings hold a person in the past. With determination they can still choose to answer the '*call*' freely. Whether the '*call*' is answered freely in the present is entirely our own choice to make, and it is the '*having-*

*been'* in the past and the anticipation of the future that allows the present moment of action to happen. Heidegger calls this the '*moment of vision*' and whatever occurs in the '*moment of vision*' is authentic Dasein. This '*moment of vision*' can be seen in Chloe's story where she said that she '*just made the decision to knock it on its (midwifery) head*' (Chloe, 86). The three dimensions form a unity. It is this projection of '*being-towards-death*' that allows us to understand the true nature of authenticity. The midwives each had a '*having-been-ness*' as well as a future possibility that was projected and the combination of these gave the present, which is the place where authentic thinking could take place. This meant that the midwives had midwifery in their past and the possibility of homeopathy in their future and this was the moment of authenticity for the midwives. It was the point at which they had a free choice and they chose to be homeopaths, based on their '*having-been-ness*' and the projected possibility. They could have chosen to ignore the '*call*' or '*letting reach*' if they wished and retreated into '*the they*'. If they had retreated into '*the they*' they would have lost themselves in their '*everydayness*'. No midwife in the study, regardless of whether they remained in the NHS, chose to return to '*the they*'. Zoe said how she does '*feel that my approach to midwifery is different and does make a difference, and I do try and influence people I am working with*' (Zoe, 196).

### 7.1.5 The Call

To be truly authentic requires thought; Heidegger considered what it is that makes us think. He says it is '*the call*' to thinking, explaining that '*to call*' has a range of possible meanings.

At its simplest it means the defining and naming of things. In this context there is the thinker and thinking is its object (Vocamus 2014). Heidegger went on to state that '*to*

*call*' also has another meaning, one of *'real significance'* and this is when *'to call'* means to set into action or motion or to start something. In this context Heidegger suggested that *'to call'* is *'not so much a demand as a letting reach'*. This *'letting reach'* is an invitation, thus Heidegger asked *'What is it that appeals to us to think'* or what is it that *'invites us into thinking'*. When addressing the call in this manner, the thinker becomes the object of the action, the one who is invited into thinking (Vocamus 2014). Heidegger (1962) explains that it is the call itself that calls or opens us up to thinking. So it is the thought itself that calls us into thinking. This call *'needs to be thought, wants to be thought, demands to be thought'* (Vocamus 2014).

The call is described by Harman (2007), as the angst of being towards death, and the possibilities opened up by that knowledge. It is also interpreted as *'conscience'*. Conscience calls upon us to be guilty, and this feeling of guilt frees us into responsibility for our own being in the world. This means that if Dasein experiences the call of conscience it calls Dasein into its own possibilities and as a consequence can never be part of *'the they'*.

There is also a third *'implied'* way in which Heidegger used *'the call'* and that is where there is a call to thinking, but rather than being called to the activity of thinking we are called to a state, condition or way of being. To be called or drawn into thinking is to be presented to thinking, not to act upon it, but to be in relation to it. The call *'does not just give us something to think about, nor only itself, but it first gives thought and thinking to us, it entrusts thought to us as our essential destiny and thus first joins and appropriates us to thought'* (Hill 2010). In his *'Letter on Humanism'* (1947, p.1) Heidegger stated that *'thinking accomplishes the relation of Being to the essence of man'*. Thinking precedes action.

This thinking has been described as a type of '*angst*', '*anxiety*' or '*conscience*'.

Conscience calls upon Dasein to feel guilt, and it is the feeling of guilt that frees Dasein into responsibility for being-in-the-world. If there is a call of conscience it calls Dasein into its own possibilities and therefore it cannot be part of '*the they*'. The midwives each have a call to conscience that frees them and allows them to answer this call to thinking and so make choices based on their own self. It is this that allows them to consider homeopathy as a choice. The conscience manifests itself as '*angst*'. Some of the participants, particularly those who feel they have no option to leave the NHS, experience this '*angst*' most acutely. Heidegger described what he meant by '*angst*' in his writings. '*Angst*' is particularly important as it provides clarity about the fundamental nature of human existence (Frostburg University 2013). It is through experiencing '*angst*' that people can learn who they are as human beings. '*Angst*' needs to be distinguished from fear. To fear is to be afraid of something in the world such as being burgled or lacking money. Fear is identifiable to a greater or lesser extent; however it remains tangible regardless of whether the fear is reasonable. *Angst* on the other hand is a dread that is a mood or is a feeling that is non-specific; therefore it cannot be described or identified. '*Angst*' is for Heidegger a meeting with '*nothing*' or '*nothingness*' (Frostburg University 2013). Therefore for Heidegger '*angst*' is equal to '*nothingness*'. This raises a question about the nature of '*nothingness*'. Philosophers argue that '*nothingness*' is not a void but instead a '*drawing away*' from the world. In a state of '*angst*' the world changes its form, and the person experiencing '*angst*' sees their ordinary environment as altered into what is described as '*alien or uncanny*'. The cares that usually connect the person to their environment fade away, and in doing so '*angst*' causes a flight away from Dasein (Scott 2013). Heidegger stated:

*All things, and we with them, sink into indifference. But not in the sense that everything simply disappears. Rather, in the very drawing away from us as such, 'things turn towards us'. This drawing away of everything in its totality, which in angst is happening all around us, haunts us. There is nothing to hold*

*on to. The only thing that remains and comes over us.... In this drawing away of everything....is this 'nothingness'.*

(Heidegger Sein und Zeit 40)

Heidegger relates '*angst*' to feeling uncanny. When a person is '*angst ridden*' they feel displaced and disconnected with their normal lives, and it is this displacement that makes things feel unfamiliar or pointless. This leaves a person '*suspended*' and what is left is according to Heidegger a state of '*being there*'. It is in this state that a person can choose to be authentic or they can disappear back into a world where they are inauthentic, and where they lack a freedom of action.

This '*angst*' left most of the midwives in a liminal space, where they were able to truly experience authenticity and it is in this moment of clarity that they were enabled to make an extraordinary choice or what can be described as a potentiality for choice. They became authentic when they were able to make a resolute choice for themselves. An example was provided by Grace (19-22) who told of the '*angst*' she had experienced. She remembered how she had felt:

*'humiliated and distressed, humiliated and kind of crawled out on my belly thinking who am I, just a nurse and a midwife and what do I know about anything'.*

when she had taken her child to the doctor. This angst left Grace in that liminal space where she did not know what to do or where to turn. At that time she knew nothing about homeopathy but said to her husband (Grace 25-30):

*'I am going to find a homeopath, not really knowing what it was about, not knowing anything about anything really, and just thought it is an alternative medicine and then luck, no synchronicity had it that week we were invited to an*



*organic farm opening day and who should be there but a homeopath, and that is how it started'.*

Through '*angst*' Grace was invited into thinking, and this thinking preceded action. The '*call*', or '*letting reach*' of homeopathy was always, already there as a possibility but was not made possible until this moment in Grace's life.

#### **7.1.6 The Clearing (Lichtung)**

The call to thinking takes place within '*the clearing*'. This clearing can be thought of as a kind of clearing that opens up in the woods or forest where the branches thin out and let the light through, it can also mean '*lighting*' as in '*shedding light on something to make it more easily seen*' (Phillips 2008). Heidegger said of the clearing: '*In the midst of beings as a whole an open place occurs, 'there is a clearing*' (Heidegger 1962: 53). Heidegger talked of Plato's cave in the Basic Problems of Metaphysics (1927), stating that man's life is like a cave, where all vision needs light, although the light is not visible. He went on to say that '*The Daseins coming into the light means its attainment of the understanding of truth in general*' (Heidegger 1954: 284/403). Dasein exists within this clearing, in the space of the clearing, '*where the light of Being shines and unveils Beings into their truth*' (Livingstone 2005). Krell (1986, p.92) considered that this light is best explained as '*lighting in the sense of clearing, making less heavy or burdensome*'. Thus illumination can only happen in the clearing, or the space. So for Heidegger, '*we must first think aletheia, unconcealment, as the clearing which first grants being and thinking and their presencing to and for each other*' (Heidegger 1988: 75). Unconcealedness is that which grants to us the possibility of taking things as phenomena (Arola 2008).

Thus, once the midwives were '*attuned*' to possibilities, the clearing opened up to them, and enabled them to see what had previously been inaccessible to them. The things that happened to them made them receptive to possibility. It is in this clearing space that their past can be seen and future possibilities can be chosen. In the clearing they can choose to return to the '*They*' or take up one of the other possibilities illuminated. Emily talks of how her reaction when told that '*we don't do anything at this age because they don't get ear infections*' (Emily 44-46) about her three month old son. She said '*it set me off on the usual trek of looking for something else*' (46) which could be considered to be the clearing, spoken of by Heidegger. At this point Emily knew she needed to do something different, but did not know what form that might take. It was in this space that the '*call*' or '*letting reach*' to homeopathy was heard.

Generally however, we live our lives not noticing the things around us. It is when something is no longer working, as in Emily's or Grace's lives, or no longer there anymore that we start thinking about them. Heidegger believed that it was in moments like these that things like homeopathy '*become unconcealed*'. According to Heidegger by remaining within our own unquestioned existence we allow the concealing to hold sway. Emily could, at that moment have chosen the route of antibiotics for her son, and continued to work as a midwife in the same way that she always had. Heidegger (1949: 132) went on to say that '*Whenever the concealment of beings as a whole is conceded only as a limit that occasionally announces itself, concealing as a fundamental occurrence has sunk into forgottenness*'. Heidegger calls this '*aletheia – truth as unconcealment*'. Heidegger explained '*This unconcealedness comes about in the unconcealment as a clearing; but this clearing itself, as occurrence, remains unthought in every respect*' (Heidegger 1982: 39).

### 7.1.7 Summary

In summary, the midwives remain content in their jobs as midwives until a crisis created a challenge in their lives. They attempted to achieve a resolution within the NHS, which was familiar territory to them as they were insiders in the system. The challenge came when they were unable to find any satisfactory answers to their crisis and so they started to search for alternative solutions. This '*angst*' or '*call to conscience*' started them thinking, but they could only think in the '*clearing*'. They were thrown into the world and as such had a '*care*' or '*concern*' in the world as Dasein, and in the clearing the possibilities open to them were illuminated. The possibilities that were projected were only made possible by their momentary place in the world, and they were made susceptible to these possibilities by a mood that underlay their '*concern*'. Heidegger made the claim that the world exists as an interrelated network with everything connected to other things. These connections pre-exist the experience, they must already be there to be experienced. It is this interconnectedness that both makes the experience possible and allows meaning (Heidegger 1962: 59-105). Thus the midwives experienced a '*letting reach*' towards homeopathy. If we accept that Dasein is at centre stage, then the possibilities that arose for them were dependent on their past, and their knowledge of being toward death. They are only where they were at that moment because of the past and it is their experiences that would enable them to be free to choose from a range of possibilities. It is this freedom that is Dasein's potentiality for authenticity. It is that moment of freedom to choose homeopathy as one of the possibilities illuminated in the clearing that enabled the midwives to break away from '*the they*' into their potentiality as authentic beings in the world. However, achieving authenticity is not about achieving a higher state of being; it is not hierarchical in any way. It is when Dasein becomes lost in the '*They*' that it becomes inauthentic. Being authentic or inauthentic is not a fixed state. There is a perpetual movement between the authentic and inauthentic states. The participants remain living in a world of the

'They' but see glimpses of authenticity and it is these glimpses that contribute to the person they have become.

Authenticity does not exist in isolation. My aim is to explore whether a practitioner who stays working in a system that appears to lie in direct contrast to their values and beliefs can ever be considered to be truly authentic. The next section of the chapter analyses whether there is a link between authenticity and autonomy.

## 7.2 Autonomy

The notion of autonomy featured in the participant's narratives. Jessica (225-231) stated that she could not see herself continuing with her midwifery career. She said that:

*'I couldn't see myself in that structure at the minute because this is far freer and you feel more in control of what is happening to you as well as for your client, you don't feel governed by whatever anyone else has said and so there is no room for that in the midwifery structure at the minute so that is not for me because I like the autonomy of this even though I felt quite autonomous as a midwife. But the autonomy in midwifery is governed by the rules and regulations, as does any practice but to a far greater degree in midwifery.'*

As a way of keeping her authenticity Jessica gave up practising midwifery. However, autonomy also featured in Zoe's narrative. Zoe stated her belief that '*we are autonomous practitioners so long as we follow guidelines ... it is prescriptive*' (Zoe 39). Similar concerns about '*autonomy*' were also found when reviewing the literature. This revealed that midwives perceived a lack of autonomy as a barrier to their use of CAM in maternity services (Mitchell and Williams 2007). This is despite the midwife being recognised as a responsible and accountable professional working in partnership with women (ICM 2008). The midwives appear to be using the word '*autonomy*' with its

everyday meaning of '*control over one's own affairs*' (Oxford English Dictionary 2014). As a consequence I determined to examine the link between authenticity and autonomy, particularly in those midwives who remained. I wanted to explore whether adhering to Trust guidelines and policies means that those midwives can ever be considered to be authentic and autonomous.

Philipse (1998) argues that Heidegger's ideal of individual authenticity as previously explored can be seen as the final element in the development of radical notions of an autonomous person. Philipse distinguishes degrees of autonomy, each representing an individual stage in its development. The lowest level of autonomy is where the '*They*' informs a person's thoughts and actions. This would be in accordance with the midwives as they once behaved. Zoe recognised this dilemma when she said that '*we are autonomous...so long as we follow guidelines...it is prescriptive*' (Zoe 39). The next level is where there is the rejection of '*traditional norms*' because others determine them. At this level the person would look outside tradition for insights. These insights would exist at a deeper or higher level. Examples of this would include '*Plato's Forms, God's ideas or empirical principles of human nature*' (Philipse 1998 p.263). By adhering to these influences authenticity could be achieved. Kant however disagreed, believing that these were still external determinants. Autonomy for Kant meant the use of rational insight. In contrast, Heidegger did not believe that Dasein is inherently rational, although as an animal, it can choose that mode of being. Heidegger moved the debate forward, stating that an autonomous person cannot rely upon any ideas or principles in making their choices. This for Heidegger, means that all moral, political norms or ideas belong to the '*They*' world, and consequently should be disregarded by people who are authentic. For Heidegger, any choice is justified as long as it is a resolute choice. Authenticity occurs when a decision is made voluntarily and with determination (a resolute decision). This, for Heidegger is the link between authenticity

and autonomy. Philipse (1998) disagrees, and argues that it is not possible to be resolute without relying on some element of pre-existing cultural roles and standards. If this argument were to be accepted the participants would find themselves in the position of having achieved a freedom of thought existent within rules and regulations. Zoe believed that she had been able to maintain both her authentic and autonomous selves. She provided the example of how, although she had to work within the Clinical Negligence Scheme for Trusts (NHS Litigation 2012), she was prepared to '*break the barriers of all the protocols*' when she believed it is right, but would do this in a collaborative way by '*getting the registrar on board*' (Zoe 288-292).

Midwifery uses the language of '*autonomy*' extensively. WHO (1992, p.3) define a midwife as '*an autonomous practitioner of midwifery, accountable for the care she or he provides*'. According to Herron (2009) the meaning of '*autonomy*' in midwifery is both complex and variable. Downie and Calman (1994) suggest that an autonomous person is one who possesses the ability to decide upon and implement their own ideas or strategies, within their own value led framework. This is very similar to the argument proffered by Philipse (1998). Beauchamp and Childress (2013) describe it (autonomy) as a condition where an individual is in control of their own life and living free from the control of others. This suggests a person who is both autonomous and authentic (Sorral 2005). McParland *et al* (2000) identify three levels of autonomy, the physiological, the personal and the social. Personal autonomy, which is the autonomy most often discussed, occurs when a person has the freedom to act in accordance with their own will, has independent thought and who is ultimately able to exert control over the choices they make (Rogers 1983). This is the ability to be truly authentic. This is the type of authentic choice made by the midwives (Chloe, Jessica and Grace) when they decided they could not continue to work as midwives. Their transformation was so radical that they felt they had no other option but to leave. There was too much

dissonance between their perception of the role and their emergent selves to enable them to continue as midwives. Chloe stated how she *'found it difficult, the more I learned about the philosophy, the more I hated my job'* (Chloe 49-50).

Stevens (1984), however, proposes that the social level of autonomy acts as a mediator on the physical and personal types of autonomy, and takes into account any constraining factors such as the law, social tradition, the autonomy of others, and life circumstances (Seedhouse 1992). Stevens argues that a person is only truly autonomous and authentic when they realise the extent to which they are being controlled by external factors. Jessica (261-262) had realised that her autonomy was limited stating that:

*'at the end of the day if the medical profession felt that whatever it was that you had decided wasn't the right thing then that wouldn't be getting done'.*

Davies-Floyd (1996) writes that there are two aspects to autonomy, action and thought, and she suggests it is thought that is the most important. She believes that midwives who are able to think autonomously are able to *'bend or manipulate'* the system, as Zoe did, to provide women centred care, often within a system that is over bureaucratic and technological. This view is supported by some of the workarounds that the midwives in the study developed. Even though they were not permitted to use homeopathy in their Trusts, some of the midwives were able to find ways of promoting what they believed to be a better approach for the women. Jessica (135-139) said that she had:

*'said for people to go to practitioners, i.e. for a really bad back I would advise them to go to an osteopath rather than just say we can't do anything for you we will send you to the physiotherapist, but you have got a 6 week wait and in the meantime take these very strong painkillers which they are worried about the side effects for the baby.'*

Chloe, recognised limits placed on her autonomy, nonetheless she chose to circumvent these and admitted that she was '*naughty*' and would send patients to homeopaths even though she was not able to prescribe herself. Viewed from this perspective it could be argued that autonomy is a personal characteristic that enables midwives to remain authentic in some form. Chloe was not overtly rebellious, but still ensured that her patients received what she believed to be the best care, even if this meant going against the regulations.

Grace (181-185) was acutely aware of her lack of autonomy, believing that although:

*'They say we are autonomous that is the other point, but also the woman is supposed to have free choice and supposed to be in charge of her own body and birthing process and she is not. We used to teach that as community midwives and empower them, only for them to go into hospital and have it completely stripped away, they become completely overridden by the medical model.'*

Grace's views reflect the rhetoric in midwifery that suggests that a key element of being a midwife is to help women make decisions about how they would like their babies to be born yet she is unable to offer this. Emily (202-203) agrees with Grace's sentiments saying that mothers have some choice but only up to a point:

*'It is women's choice out of what is available, that's the NHS we have at the moment. Money is making those decisions about what is available'.*

Zoe though, recognised the tension between the different stakeholder positions. Whilst she says that guidelines state that a midwife could support a woman's choice as long as she was independently insured and a registered practitioner (Midwives Rules 40; 40(2)), she also explained how the Trusts have to comply with the Clinical Negligence Scheme for Trusts (CNST). Zoe (18-25) noted:



*'I think that one of the biggest barriers to using homeopathy that we have are the NICE guidelines. The NICE guidelines categorically state that it cannot be used. The difficulty is that all the trusts now, because of their insurance, have to comply with the CNST and the CNST base all their assessments on the policies and procedures following NICE, and NICE has a section in their guidance.'*

Jessica (24-31) said that she couldn't see herself combining the homeopathy and midwifery. She felt the impact that rules and regulations had on her ability to be a truly autonomous midwife, and valued the freedom of practice that homeopathy offered and stated that:

*'this is far freer and you feel more in control of what is happening to you as well as for your client, you don't feel governed by whatever anyone else has said and so there is no room for that in the midwifery structure at the minute so that is not for me because I like the autonomy of this even though I felt quite autonomous as a midwife. But the autonomy in midwifery is governed by the rules and regulations, as does any practice but to a far greater degree in midwifery.'*

As Jessica explained though, just because someone is autonomous it does not mean they have complete freedom to do as they wish, and this also applies to the practice of homeopathy. Feinberg (1973) and Stevens (1994) noted the need for discipline and self-restraint in practice. There is also the requirement for midwives as employees to comply with the policies of their Trust employer, and whilst they may have the training to prescribe homeopathy safely and effectively they do not have the authority to use it within their clinical practice. Gina (46-47) was very aware of this stating that although:

*'they say that homeopathy is within the scope of practice if you are properly qualified, but not in practice'.*

Hall, McKenna and Griffiths (2012) found the degree of autonomy available to midwives varied greatly depending on the model of care adopted. An example provided was

where a midwife in an obstetric unit had to ask for permission from the doctor about the use of a CAM information sheet, whereas another working in a case load model felt able to use whatever seemed to work for her. With the existence of these types of anomalies Herron (2009) debates whether midwifery in the UK really is an autonomous profession, especially within the existing hierarchical and risk management systems. Edwards (2005) concurs claiming that the profession remains defined by medical personnel, employers, frameworks and priorities.

The majority of the midwives in the study believed that both their authenticity and autonomy were limited within midwifery, and gave this as a reason for leaving the NHS. However, it could not be said that the midwives who remained are governed by the ‘*They world*’ as described by Heidegger. Whilst at times their actions have to comply with Trust guidance and policy, their thoughts remain their own. They remain resolute and are willing to act outside these guidelines with good reason and in the best interest of the women in their care. Zoe (93-95) described how she believed that:

*‘you can practice midwifery holistically, you can do that, and that is where you become a practitioner in your own right, because you can support people in a holistic way and follow guidelines and protocols.’*

Zoe (290-293) described how she would get:

*‘on board the registrar because (the mother) said just give me a little bit longer to see if I can do it, and you know he was absolutely fantastic actually because we did break the barriers of all the protocols and documented everything’.*

### **7.3 Conclusion**

This chapter has analysed the midwives stories, exploring their mode of existence and how they came to be authentic. An authentic life is one that is knowingly self-directed.

Being an authentic individual in possession of their own autonomy led to different midwives making different decisions. By any of the measures discussed, the midwives who left the NHS could be considered to be both authentic and autonomous. This leaves a question about whether the same could be said of the midwife homeopaths. The midwife homeopaths had greater restrictions on their professional autonomy; however I would posit the argument that they also remained autonomous. They worked within the framework of their own beliefs and values making resolute decisions. One of the differences identified between the midwives, is that those who left the NHS were concerned over their inability to use homeopathic remedies and saw this as central to their autonomy and authenticity. Those who remained viewed their practice differently, and whilst they recognised, and at times expressed their dislike about the restrictions placed on their practice, they had a very clear focus on seeing a '*holistic picture*' (Zoe 223). They were more concerned about creating change as well having a focus on the development of their relationship with women. It is this element that went to the heart of their authenticity and autonomy.

The midwives who left did so as they felt that the limits placed on their autonomy directly assaulted their authentic selves. However, my interest lies with those participants who stayed as midwives in the NHS. They both talked about the relationships that they developed with mothers and families. They stated that there was something about being a homeopath that enhanced their ability to provide care.

The following chapter analyses the impact that training as a homeopath had on the two midwives who remained in the NHS. It does this through the lens of the therapeutic relationship. This offers a hypothesis that can be linked back to the original observations about evidence-based medicine and a scientific bureaucratic NHS set out

in chapters one and two. The NHS has over the past three decades been rooted within a neoliberal paradigm that has resulted in increased marketisation, bureaucracy and target setting that has allowed the notion of 'care' to become secondary. The therapeutic relationship is posited as one solution to the NHS crisis in care. This is explored in the final discussion chapter.

## Chapter Eight: Viewing data through the lens of the therapeutic relationship.

### 8.1 Introduction

This chapter is an in-depth study of the two midwife homeopaths, who remained in the NHS, to generate a hypothesis. The study uncovered the midwife homeopaths becoming authentic by '*re-engaging*' with '*being with woman*'. An important element of the midwife homeopath's empowerment is through their own recognition of the importance of the therapeutic relationship. This is an important element of their stories, as I postulate that it is not only their authenticity that enables them to provide effective '*care*', but in addition learning about homeopathy enables a clear mechanism for supporting women. Homeopathy, as Zoe pointed out, is about much more than just prescribing remedies. In order to reach the point at which a homeopath can prescribe, they must understand a great deal about the patient/client. I argue that it is in their re-engagement with the importance of the therapeutic relationship and their enhanced understanding of the patient/client that their '*care*' emerges.

In chapter six, '*Metamorphosis to midwife homeopaths*', I outlined the basic thematic structure of the midwives stories as they were shared with me. The participants were able to provide comprehensive and textured stories about their personal transformation. They presented a picture of their transformation from blissfully innocent midwives to students and finally to midwife homeopaths. Each midwife experienced varying degrees of personal and professional struggle. For some this meant they felt they had no option other than to leave the NHS and their careers as midwives to become homeopaths in private practice. Two participants

were able to stay within the NHS and straddle the two paradigms. This chapter examines the nature of the relationships that these two midwives were able to develop with the women in their care and their families. Training as a homeopath enabled the participants to emerge as authentic practitioners. Their changing concept of self and how they related in the world as homeopaths gave them a set of tools that they adopted, and this resulted in enhancing the care they were able to offer in clinical encounters. This was extremely hard to do within the prevailing evidence-based, scientific approach to care, so this analysis provides a synthesis between midwifery and the therapeutic relationship as a hypothesis for solving the NHS ills authentically.

The chapter builds on the in-vivo accounts of chapter six, and the exploration of their authenticity and autonomy in chapter seven, culminating in the drawing together of a theoretical framework for the interpretation of the midwives stories as they materialised from my immersion in the data. In this final analysis, I specifically set out to examine the therapeutic relationship between the midwives and mothers and their families. I explore how the midwife homeopaths utilise the skills and values they developed during their time studying and then practising homeopathy as NHS midwives. The transcripts were reviewed and passages highlighted to find patterns in the text. These nascent meanings were contrasted with the literature. Ricoeur (1981) argues that interpretation is different to explanation, as it entails both a complementary and reciprocal relationship that becomes reconciled by reading. At the same time, he also considers that text and speech are different to one another. A speaker relates a '*real*' world to the listener, whilst text presents an '*imaginary*' world where the text needs to be interpreted by a reader who fills in the gaps in order to derive meaning. Ricoeur (1981) called the interpretive phase '*appropriation*', and explains the ultimate goal of interpreting a text as '*self-*

*understanding*'. By interpreting a text we make '*one's own what was initially alien*'.

The midwives narratives will be analysed to derive meaning and frame the therapeutic relationship within a range of existing theories before developing a conceptual map.

The participants held that being a homeopath was not just a job, or even profession, but instead an identity and a way of '*being*'. Learning homeopathy changed their values and way of thinking. Emily (118-119) recalled how it changed her as a person, saying:

*'so just the whole way I look at life as a person, like as a midwife has changed by what I have learned through homeopathy'.*

Even when unable to prescribe homeopathic remedies, the midwives possessed a set of skills, values and beliefs about caring for others that were central to their '*being*'. Some of these skills, values and beliefs, were already held, but many were developed or enhanced through their study of homeopathy.

Homeopathy, in common with most professions, enjoys a number of unique features that, taken in combination, define its practice. An important feature of homeopathic practice is the '*receiving*' of a homeopathic case from each patient. It is this information that enables a homeopath to build up a picture of the person before going on to prescribe a remedy. The homeopathic case taking process helps the practitioner develop a therapeutic relationship with the patient. Both the case taking and the development of the therapeutic relationship depend greatly on the values and beliefs held by the practitioner, and these in turn stem from the fundamental principles taught in homeopathy.

The midwives who remained in NHS midwifery practice were acutely aware of the boundaries to their practice, acknowledging the requirement to follow hospital protocols and CNST guidelines. Examples of this were provided by Zoe (90), who noted that:

*'whilst I am working as a midwife I have to have my boundaries in place'.*

and Emily (220-221), who, although not happy with the restrictions placed upon her practice, said that she:

*'has learned to live with it...because that's the service I'm working in, I have to tow the party line, they pay my wages, and if I want to stay there and do it, that's the line I have to take'.*

Nonetheless, even though they were unable to prescribe homeopathic remedies, Zoe believed that there was still a great deal they could do. What was apparent is that they had a different focus to the midwives in the study cohort who left the NHS. The midwives who left did so because they felt their authenticity and autonomy had been fundamentally challenged. Jessica (105-108) noted that she had felt:

*'Frustrated, that's why I wouldn't go back. I couldn't, I wouldn't want to, wouldn't say I couldn't, wouldn't want to look after women and give them conventional treatment, drugs things like that when I know how much better it could be for them using homeopathy, and then I just wouldn't be able to use that at all.'*

She went on to explain how she could not see herself continuing to work as a midwife, stating that:

*'I cant see myself doing homeopathy and midwifery together and the further down this route I go then I couldn't see myself in that structure at the minute because this is a far freer and you feel more in control of what is happening*



*to you as well as for your client, you don't feel governed by whatever anyone else has said and so there is no room for that in the midwifery structure at the minute so that is not for me because I like the autonomy of this' (Jessica 224-229).*

Grace (168-170) told of how she felt that she:

*'had to really watch myself, I couldn't leave any 'I' undotted or any 't' uncrossed in my practice and I almost felt like it was a bit of a waiting game for me to make a mistake and slip up so then they could get rid, as this person was not doing what everyone else was doing'.*

Grace (191-195) in explaining how she felt about autonomy said:

*'They say we are autonomous that is the other point, but also the woman is supposed to have free choice and supposed to be in charge of her own body and birthing process and she is not. We used to teach that as community midwives and empower them to go into hospital and have it completely stripped away, they become completely overridden by the medical model.'*

Emily and Zoe experienced many of the same issues, however they chose to focus their attentions differently. The values and skills they had developed during their homeopathy training led to their desire to change the type of care offered to women.

Emily (295-299) stated that for her:

*'when you train as a homeopath and are a midwife, I don't think you are either one or the other. That's good because whether you give the remedy or not, your model of care, the way that you work, the way that your thought processes work have got to be good for the woman. I don't think you can switch it off and on, you can't be a midwife today and a homeopath tomorrow because it is integral in you'.*

Both Emily and Zoe had taken on roles that enabled them to influence change. For Emily (260-273) the change had been imposed as a result of staff cuts, however she stated that:

*'part of me wants to be there to support the change and get a suitable service for these women and that's the way I can do it and I am perhaps*

*going to be better use to more women by working at that level than going back and having a case load of 120-140 women and they get the benefit of it but all the other women don't.....I am trying to incorporate this for every woman.'*

For Zoe (255-274), it was about influencing policy, and she believed that her role as a Clinical Risk Manager allowed her the scope to do that. She described how she attempted to affect the policies she thought restrictive:

*'We are working very hard as a clinical risk team because of what has happened recently within the trust. People are working very defensively and that is to the detriment of the women because they are rushing to CTG's, and rushing to say 'but we have a trace of this baby and it is alright', and we are working very, very hard to get them out of that frame of mind, looking more at we don't need this.*

*The policies, procedures and guidelines that we are updating are reflecting that, if it doesn't need to be done. In fact we have actually put a part into the guidelines that says if you are going to use continuous monitoring on a lady or you are going to do any kind of fetal heart tracing you have to write down and document a reason, so clinical risk can work in a way of trying to support people, and to looking at normal practice. We are trying to use it for good, saying we are supporting you in this, the policies and protocols say that you don't have to do that.*

*One of the biggest reasons for C-sections is the use of continuous monitoring and so to try to reduce the C-section rate, and to get things more on to an even keel all the policies and procedures that we are writing say that they have to follow guidelines, and all sorts of things have been written to support midwives so that they don't feel they have to go down that route to justify not doing a procedure, and so I feel that all that is very important and we are trying to give midwives confidence.'*

Zoe wanted to empower midwives to enable them to act as autonomously as they are able. She considered it important that they act with confidence. She used her values and beliefs to create what she believed was a positive change.

Both Zoe and Emily believed that even though they worked as midwives they were still homeopaths as well. There are implications for practice that result from embracing these beliefs, and Emily (118-119) described how:

*'the whole way I look at life as a person, like as a midwife has changed by what I have learnt through homeopathy'*

They report that they felt differently to other midwives, and learning homeopathy had, for Emily (114-115):

*'really reinforced the whole low risk, normal, listening to your body, nature understands and tap into that first'.*

This ideology is resonant of the social model of childbirth discussed earlier in chapter two. Proponents of a social model view pregnancy and birth as a natural physiological event, believing the majority of women are capable of having a normal and safe childbirth, with little or no medical intervention (Bryers and van Teijlingen 2010). This view was echoed by Grace, one of the midwives who left. She was unhappy about the predominance of the medical model in maternity care. She recounted how as soon as women were in the hospital environment:

*'they had a monitor strapped on' (186), and if the woman failed to progress within the '4 hours, or the 6 hours whatever, **they** would start to intervene' (Grace 187-188).*

Grace used the word '*they*' to refer to the system, and those who followed a biomedical approach. She had started to see them as being separate and no longer associated with her. This, in Heideggerian terms represents her move into '*authenticity*'. Grace no longer identifies with the '*they*' midwives and system. The '*they*' thought in a biomedical way and intervened in normal processes.

Emily also reports how her emergent worldview has also provided clarity for her over what she describes as the 'fear issues'. Emily (116-118) said that she had:

*'seen that (fear) so many times in play of ladies who are fearful and if you can overcome that, not necessarily by homeopathy, but by other things then you can make a huge difference to their outcomes'.*

Fear of childbirth has been identified as a neglected issue in women with up to ten percent of parturients reported as experiencing severe fear (Saisto and Halmesmaki 2003). They state that mothers experiencing fear are more likely to request a caesarean section to help them manage it. The authors describe Swedish and Finnish reports that demonstrated that when mothers were able to discuss their fear and anxiety, more than half of them withdrew their request for a caesarean section. Emily believed that her ability to recognise and manage this fear had been enhanced by being a homeopath.

As both Zoe and Emily observed, apart from prescribing a remedy, treatment by a homeopath relies on case taking, the possession of a set of professional values, and the development of a therapeutic relationship. The midwives believed that these skills significantly enriched their practice of midwifery, with Emily commenting that being a homeopath provided her with '*enhanced skills*'. Zoe (258-260) maintained that:

*'I think I still do look at people in a very holistic way, which I always did to a degree, but not to the degree that I did after I did my homeopathy training.'*

This chapter examines, through an exploration of their practice, how these skills and values have impacted on their midwifery. Previous studies on doctor-patient

relationships have demonstrated that when these contain effective communication they can help to improve patient outcomes, as well as provide a fulfilling experience for the practitioner (Hartog 2009). It has been noted that CAM consultations often have better reported outcomes than general medicine because of the enhanced communication between the CAM practitioner and patient (Busato and Kunzi 2010). In their attempt to improve outcomes, homeopaths make greater use of patient centred approaches than do GP's (Hartog 2009). Patients who consult homeopaths report themselves as being highly satisfied with treatment (Spence, Thompson and Barron 2005). In the absence of any consistent evidence of efficacy in homeopathy (Linde, Clausius, Ramirez, *et al* 1997, Linde Scholz, Ramirez, *et al* 1999, Shang, Huwiler-Muntene, Nartey *et al*, 2005, Ludtke and Rutten 2008), it has been suggested that much of the success of homeopathy can be attributed to the therapeutic relationship developed between homeopath and patient. (Jonas and Jacobs 1996, Frank 2002, Becker-Witt, Ludtke, Weissshuhn, *et al* 2004, Hartog 2009).

The next section examines the synergy in this area for the two participants who stayed in the NHS.

## **8.2 'Taking the Case'**

During the consultation it is usual practice for a homeopath to take an extensive case history from the patient (Owen 2007). This case history is based in the patient's own experience of their illness. Bell (2004, p.124) writes how:

*'symptoms can be bio-psycho-social-spiritual in nature, typically including both disease specific and non-specific manifestations. Grasping patterns and themes of the symptoms is crucial...homeopaths synthesise their observations of a patients' appearance, verbal and non-verbal behaviours,*

*resilience to daily hassles and major life events, personal medical status and history, family history, and capacity to live fully in joy and purpose’.*

Emily (125) remarked on her ability to take a case saying that:

*‘every woman that I book still has their case taken (homeopathy) and that has been commented on by students about the way that I can follow a case’.*

Emily (128-132) recognised that she developed this skill during her training as a homeopath, and she reflected on the way she:

*‘know(s) my way around the notes but because I can take the case and interact with the woman I can dot about in the notes and get the information and I tend to have less of coming back later and saying ‘I forgot to tell you’ because as they are talking I don’t interrupt them to go back to the next tick box and it doesn’t get forgotten about. So I think certainly the case taking skills have made a big difference’.*

In doing so, Emily was carrying out one of the cornerstones of homeopathy.

Hahnemann stated in ‘*The Organon*’ that a homeopath:

*‘should listen particularly to the patient’s description of his sufferings and sensations’ and ‘attach credence especially to his own expressions wherewith he endeavours to make us understand his ailments’*

(Hahnemann 1810, aphorism 98).

This remains as one of the essential skills required by the modern homeopath. The National Occupational Standards for Homeopathy (NOS 2011) when describing the skills, knowledge and understanding required of a homeopath include a specific competency relating to the ability to take the case of a patient (CNH15). As well as understanding the disease process, the homoeopath is expected to know how to act professionally within the remit of the law. (Society of Homeopaths 2013a).

According to Skills for Health (2011, p.35) knowledge, understanding and skills include:

*'making the patient feel at ease; enabling them to talk about their lives, needs and concerns; not imposing one's own beliefs, values and attitudes on others; and valuing another's beliefs, values and attitudes; recognising and interpreting appearance, body language, speech and behaviour; an understanding of family dynamics and individual/practitioner relationships; how to be supportive to individuals; how to show respect for an individual's privacy and dignity; a knowledge of the scope and significance of physical, mental, emotional, social, spiritual and environmental factors which should be explored with patients; an awareness of the patterns and themes emerging from the consultation and the ability to manage uncertainties without reaching hasty conclusions'.*

Owen (2007, p.163) describes the process of case taking as one where:

*'when in consultation with a patient the universe shrinks and your senses extend to encompass the patient in a dynamic interaction, allowing you to perceive the patient at a deeper level. Your world becomes your consulting room and when you truly see the case in its entirety the past stands still and the room disappears as you dance the homeopathic dance.'*

Emily, in enacting authenticity through the therapeutic relationship, stated how she took a *'homeopathy case'* from each of the mothers she booked in. She reflected that, at the same time as taking the information that she needed from the patient such as date of last period, previous obstetric and gynaecological health, and family history, she also listened subtly to their personal pregnancy narrative.

Eyles (Eyles, *et al* 2010) carried out a study that explored the homeopathic consultation from a homeopaths perspective. From this, Eyles developed a model of a classical homeopathic consultation conducted by practitioners trained in the United Kingdom. Eyles's research revealed that *'connecting'* to the patient was central to the consultation, with a number of further categories linked in to this. Other categories included *'exploring the journey'*, *'finding the level'*, *'responding therapeutically'* and *'understanding self'*.

When comparing my own study to that conducted by Eyles et al (2010), the fact that the midwife homeopaths do not conduct either a formal homeopathy consultation, nor expect to prescribe a remedy are important distinguishing features. This means that not all the categories identified will be relevant. These themes were a useful framework for analysing the practical meaning of the data for midwives who are both homeopaths and practising NHS midwives.

### 8.3 'Connections'

Zoe (117-140) recounted how she had been able to care for a young mother. This example shows the various themes at play. She very clearly connected with the couple, and remained respectful yet attentive to their needs. She did not impose herself on their experience other than to facilitate the birth.

*'A young girl came to us from a midwifery led unit because she was post mature, she actually went into labour spontaneously so didn't need any induction but she was within a consultant led unit and she brought along a friend to be her birth partner. So she came across to the ward and we discussed the sort of things that she preferred for her birth, enough so that I could write a plan on what she preferred. She went into a room, we made the lights dim, got baby clothes out so that she had something to focus on...She had quite a problematic history really, but we looked at that, we did a lot of talking, allowing them to talk whenever they wanted. I went in only when I had to do what I had to, like listen to the baby, do her blood pressure, do her pulse whatever, and stayed and chatted when she wanted to, and relax when she didn't want to, and she progressed beautifully in labour and had a wonderful birth experience.'*

Using Eyles model of the consultation, Zoe had very clearly '*connected*' with the patient. Eyles participants described '*connecting*' in a variety of ways, but language such as '*engaging*', '*relating*', '*energetic connection*', and '*heart to heart connecting*'



were used. It was observed that practitioners made full use of empathy and rapport building in achieving this connection.

Eyles et al (2012, p.503) noted how a homeopath in the study described how:

*'in homeopathy a different type of listening is required, its almost as if you want to get a feeling of what it is to live inside that organism that is talking to you... so the patient is telling a story in a subjective way.'*

Certainly Zoe revealed her understanding of when to be with the patient and talk, and when not to. There was no overt homeopathy consultation being carried out, the practitioner did not label it as one, nor did the patient have any knowledge of it. However a therapeutic relationship developed as a result of Zoe's activities. For Zoe, this demonstrated the type of holistic care provided by her.

#### **8.4 Exploring the Journey Together**

The second category '*Exploring the Journey Together*' covers the period where the homeopath receives information from the patient. Eyles suggests that this consultation generally lasts between twenty minutes and two hours, and consists of the homeopath listening to the patients' narrative before discussion takes place between the patient and homeopath to unravel this narrative. The authors state that the:

*'process of exploring the patients narrative through their symptoms was described by the practitioners as not only a way for them to connect with their patients, but also as a means of gaining an understanding of the patients beliefs and perspective on their illness'.*

(Eyles, Leydon, Lewith *et al* 2010)

Whilst the purpose of a homeopathy interview is to gain sufficient information on which to prescribe a remedy, it also allows this connection to be made. By allowing the patient to talk and by understanding her specific goals (birth plan), and dreams (baby clothes), Zoe created a '*healing space*' or '*therapeutic landscape*' (Moore 2010) for the birth to take place. Zoe described how the mother came back after the birth stating how although the baby had been quite ill the experience had been good:

*'(the) baby was actually quite ill, and why the baby was ill we don't really know, we know that the baby had some kind of infection for some reason, but we don't where it came from, the baby and mum had to be transferred to a neonatal intensive care unit, but she came back to me only a couple of weeks ago brought the baby, brought us lots of gifts and goodies and they are doing a sponsored bike ride because even though the baby was ill she felt that the experience was fantastic, as what happened, the support, everything. The baby was fine. (112-117).*

## 8.5 Finding the Level

The third category described (*Finding the Level*) happens after the connection between the homeopath and patient has been made and the homeopath has reached an '*understanding*' about the patient. The homeopath evaluates how to approach the treatment for the patient. This takes into account the healing potential of the patient, how ill they are and where the focus of their illness is. Eyles found the homeopaths talked of '*energy*' and '*wholeness*' referring to the process of understanding how the symptoms relate to the whole person. Zoe has made the connection and '*understands*' the patient, letting her talk and eliciting further information from her, at the same time as thinking about the best way to approach treatment. She responded by addressing the problematic history by actively listening to the patients' narrative, and then made a choice to let her talk when she wanted, rest when she wanted and create a safe space for her. She also remained

cognizant of her need to provide appropriate monitoring within the Trust and CNST guidelines but managed it in a way that demonstrated a caring and compassionate demeanour.

## **8.6 Responding Therapeutically**

*'Responding therapeutically'* is the fourth category and posits that only once the connection has been made is the homeopath able to respond in a therapeutic manner with the patient. Homeopaths consider that patients can benefit in a number of ways from homeopathy. These benefits can be gained from the consultation on its own, the consultation and the matching and prescribing of a remedy, from the recommendation of adjunct therapies or through the adoption of various lifestyle choices. Of the subthemes in this category, it is the evaluation of the patient, the linking of the concepts of energy and wholeness, the approach to treatment and the collaboration that are important in the care Zoe was able to provide. Zoe, although unable to prescribe or recommend lifestyle choices was able to respond in a therapeutic way by connecting and making use of rapport and empathy before making an individual treatment plan taking into account the patient's needs and wants, all whilst providing a safe space. Eyles describes the situation where homeopaths mentioned occasions when their patients benefited from the consultation even before taking a remedy. When this happened some attributed it to the patient being able to talk and be listened to whilst others ascribed it to the patient making connections about their illness. Notwithstanding this, the homeopaths in Eyles' study reported the remedy as being central to the process.

## 8.7 Understanding Self

Eyles final category '*Understanding Self*' has become an important element for homeopaths and ties in with the ability to connect with patients. '*Understanding themselves*' helps homeopaths make this connection. It also helps them cope with the challenges and benefits that come with practising homeopathy. Homeopaths frequently come to homeopathy practice after training in other fields and some participants felt that this helped them identify and understand patients. In the present study all but one of the midwife homeopaths had been nurses and midwives before becoming homeopaths, whilst one midwife had been a homeopath before training in nursing and midwifery. One of the less helpful aspects of any previous experience was that potentially it could lead to a homeopath developing preconceptions about patients' prior experiences. Hence this element needed to be treated with some care. Both Zoe and Emily were very aware of '*understanding self*' and how this impacted on their interactions with patients. Emily said '*I like to think that I come from that person centred place*' (Emily 239). Zoe spoke of how she had recently experienced a traumatic family bereavement that had had a significant impact on her, and recognised the effect of this on her practice. She said that after this experience she:

*'struggled, struggled being non-judgmental really... about people that come with things because I think I don't want to listen to this,, so I stopped until I felt that I could listen to people. I lost the ability to listen because my mind was too full of my own things'* (71-74).

She followed up by saying that:

*'I have to be honest with myself , because if you are not you can't practice properly'* (84).

This echoes the findings in Eyles study where a homeopath said that *'surviving practice is about practitioner know thyself and thyself in relation to other people'* (Eyles, Leydon, Lewith et al 2010, p.7).

Further examination of Eyles study highlights some of the parallels between her findings on the homeopathic consultation and the practice of these midwife homeopaths as they cared for women. As Emily said:

*'You can't ever unlearn what you have learned so you can't ever go back, you are always changing, so there has never been a point where I have thought this homeopathy is rubbish, it doesn't work I will just go back to being a midwife because you can't undo that and I don't think it anyway.'*  
(302-305)

## **8.8 The importance of the therapeutic relationship**

Eyles study suggested a model of the consultation for classical homeopathy in the United Kingdom. In doing this, the importance of the therapeutic relationship between homeopath and patient was highlighted (Hartog 2009, Eyles, Leydon and Lewith et al 2010).

Mitchell and Cormack (1998) consider that for an effective therapeutic encounter to take place the patient must, as well being actively listened to, believe that the practitioner cares for them. In accomplishing this, the practitioner will come to understand the patient's feelings and needs. This care is evidenced by Zoe who

shares the story of a mother, where although the baby was born with an infection, she had felt cared for and supported during the birth of her baby:

*'the baby and mum had to be transferred to a neonatal intensive care unit, but she came back to me only a couple of weeks ago, brought the baby, brought us lots of gifts and goodies and they are doing a sponsored bike ride because even though the baby was ill she felt that the experience was fantastic, as what happened, the support, everything. (112-116)*

Eyles, Leydon, and Brien (2012) considered the consultation from the homeopaths perspective constructing a theoretical model of the homeopathy consultation. The study reinforced the importance of the therapeutic relationship in homeopathy. In addition to Eyles, Leydon and Brien (2012) a number of other authors have attempted to understand the homeopathic encounter. Hartog (2009) believes that the homeopathic consultation is itself a therapeutic intervention, with Frank (2002) stating that 'homeopathy is particularly well suited for such an enterprise. Its conceptual features imply a physician-patient-relationship that is fundamentally different from biomedical consultations' before going on to describe it as *'a perfect example for patient-centred medicine'*.

Owen (2007) believes that the practitioner and patient are immersed in a therapeutic relationship during the case taking process. He states that the therapeutic interaction and the therapeutic relationship are linked, and it is this homeopathic relationship that lies at the heart of any homeopathic process or encounter. Owen (p.303) takes the view that there is *'no external reality separate from the observer of the reality'* and this belief is fundamental to his understanding of the relationship that exists between patient and practitioner. This means that any changes in the observer, the observed or medium through which things are viewed,

will change the experience of the phenomenon itself. This he calls the *'homeopathic lens'*. It is through this lens that the patient voices their *'dis-ease'* and the homeopath recognises the totality of the *'dis-ease'* by the symptoms expressed by the patient. He also believes that it is this homeopathic lens that allows the homeopath to *'see'* the patient in a way that might not be achievable in another relationship. Zoe said that:

*'I think I still do look at people in a very holistic way, which I always did to a degree but not to the degree that I did after I did my homeopathy training'.*  
Zoe (216-218).

Owen considers that the *'homeopathic effect'* is an interplay between the effect of the remedy or remedies (the specific effect) and the therapeutic relationship (the non-specific effect) with the two unifying to become treatment by a homeopath.

The midwives in the study demonstrated their use of this *'homeopathic lens'* and whilst they were unable to harness the specific effects of the remedies, could still see and respond to their patients using this gaze. For Zoe:

*'homeopathy is not just about the remedies, but about the way you practice,*  
(Zoe 284).

Whilst Emily stated that:

*'I think ... the case taking skills have made a big difference'* (Emily 132).

and believed she had:

*'learned such a lot both personally and to add to my knowledge of people'*  
(Emily 143).

Zoe described how she perceives this '*homeopathic lens*' saying that she was much more:

*'alert to when somebody has something that they need to tell you and that really, really helps to know when people need to talk and people do open up and talk to me perhaps more than they talk to other people, and to look at people'* Zoe (208-212).

This is an example of what Owen (p.305) describes as the '*homeopathic dance*' where the '*the patient creates the 'music'*' and the homeopath '*tunes into*' the patient. Zoe is thus responding in way that is central to being a homeopath. The effect of seeing a mother through this homeopathic lens is that the mother feels heard and supported. Strong connections are made between the mother and homeopath.

Eyles, Leydon and Brien (2012) considered the homeopathic consultation from the homeopath's perspective, whilst Owen (2007) examined the '*space*' between homeopath and patient exploring how the '*homeopathic dance*' shapes the relationship. However, there is also a further way of examining the relationship between the midwife homeopath and their patient. Townsend argues that there are significant parallels between homeopathy practice and the person centred approach, describing how:

*'homeopathy contains within its historical and current practice an interviewing style and therapeutic stance that would be immediately recognizable to those formally trained in psychological approaches and congruent with many of their practices'* (2011, p.2).

Busche (2008) described how when transcribing and analysing Hahnemann's letters and journals, he found that Hahnemann had already anticipated some of the



essential elements of psychotherapy. Hahnemann fostered an emotional and effective relationship with his patients, asking them to actively participate in their treatment. The person centred approach runs throughout many caring professions including counselling, education, nursing, and social work. It places the patient/client central in the process and encourages their active participation in an atmosphere of mutual trust and respect. Zoe revealed her expert use of letting the patient speak and listening carefully to their narrative. This is a fundamental homeopathy skill, one that is carefully nurtured during training (Hahnemann 1978, Kent 1900; Close 1924; Roberts 1936; Wright Hubbard 1967; Whitmont 1980; Sankaran 1994; Vithoulkas 2005; Kaplan 2001; Thompson and Weiss 2006; Owen 2007; Johannes 2010; Johannes, Townsend and Ferris 2013). The homeopathic consultation is based in the patient's own language, revealing the patient's inner world (Townsend 2013). Sankaran, a homeopath, describes this process stating that:

*'The physician....needs to be like an archaeologist who excavates a treasure without touching it, interfering with it, labelling or classifying it, but purely unearthing it and making it stand out so clearly that there can be no controversy as to what it is. To do this is an art. One does not add to or subtract from, interpret or analyse anything concerning the patient. One only has to uncover the patient's inner turmoil, so that it is seen as clearly and in as much detail as is possible. One is only required to bring that which is hidden in darkness to light, to make what was unknown known. It is not simply 'case taking' but 'case uncovering' to the very depth' (1994, p.321).*

According to Townsend (2010) a homeopath progresses through the stages of homeopathy student to unprejudiced observer (Hahnemann 1810) to narrative facilitator. Townsend argues that Owen's approach although placing the patient within a homeopathic context, does not fully illustrate the skills that are required to enable the '*homeopathic dance*' to take place.

Kaplan (2001) feels similarly, and describes how:

*'The ability to listen well and say the right thing at the right moment is central to the homeopathic process. It is surprising that so little has been written about taking the case and the homeopath-patient relationship' (Kaplan 2001, p.6).*

Rogers (1961) located his psychotherapy practice in the experience of the patient, in the same way as homeopathy. In the development of his '*Person Centred Approach*' Rogers proposed '*six conditions*' that should be met. These conditions embrace the notions that psychological contact exists between the client and the therapist. The client is vulnerable, and the therapist offers the client unconditional positive regard, empathic understanding, and congruence in such a way that the client becomes aware of these elements (Townsend 2002). Bhatia comments that:

*'Hahnemann put down many guidelines for the physician in his Organon of Medicine that resonate with the principles of Person-Centred-Therapy. He mentioned the need for being unprejudiced (unconditional positive regard), listening attentively (active listening) and observing carefully, showing care to the patient (empathy), providing guidance to the patient to improve his health, using all the senses during the process of consultation (verbal and non verbal communication), with the use of only tested medicines (ethics), avoiding medical jargon etc.'* (2009, p.3).

Roger's approach according to Townsend encompasses the set of skills and attitudes held by homeopaths. It provides homeopaths with a language whereby they can communicate about the therapeutic conversation with other health professionals.

Townsend and Ferris (2013) write that both psychotherapy and homeopathy move away from an '*orthodox, reductionist medical model*', and promote the importance of vitalism/self-actualization. However more importantly with respect to the midwife homeopaths is that priority is given to the patient being able to tell their own story to an unprejudiced observer (unconditional positive regard), who can through a process of active listening, mirroring, checking out and empathic processes, work with/at the edge of awareness, at the same time as valuing equally all forms of self (symptom pattern matching) whilst also remaining true to and being aware of own self (congruence, self-awareness), and as a consequence is able to acknowledge the importance of the therapeutic relationship.

There is debate about whether these '*core conditions*' are skills or attitudes. Roger's proposed that empathy, congruence and unconditional positive regard are in fact attitudes and the absence of any of them would make the therapeutic encounter '*false*'. Sanders (2002) states that this would mean that the therapist would present a '*horrendous caricature of real human caring*' that would be '*found out*' by the patient. In homeopathy the belief in a vitalist tradition, combined with the fundamental notion of the unprejudiced observer, and the belief that a '*human connection*' is made are, I would strongly argue, ways of being, and are values that are deeply held by homeopaths. These beliefs are not tools that are used in an attempt to create the therapeutic relationship; instead they are deeply held and expressed as traits, attitudes, and values.

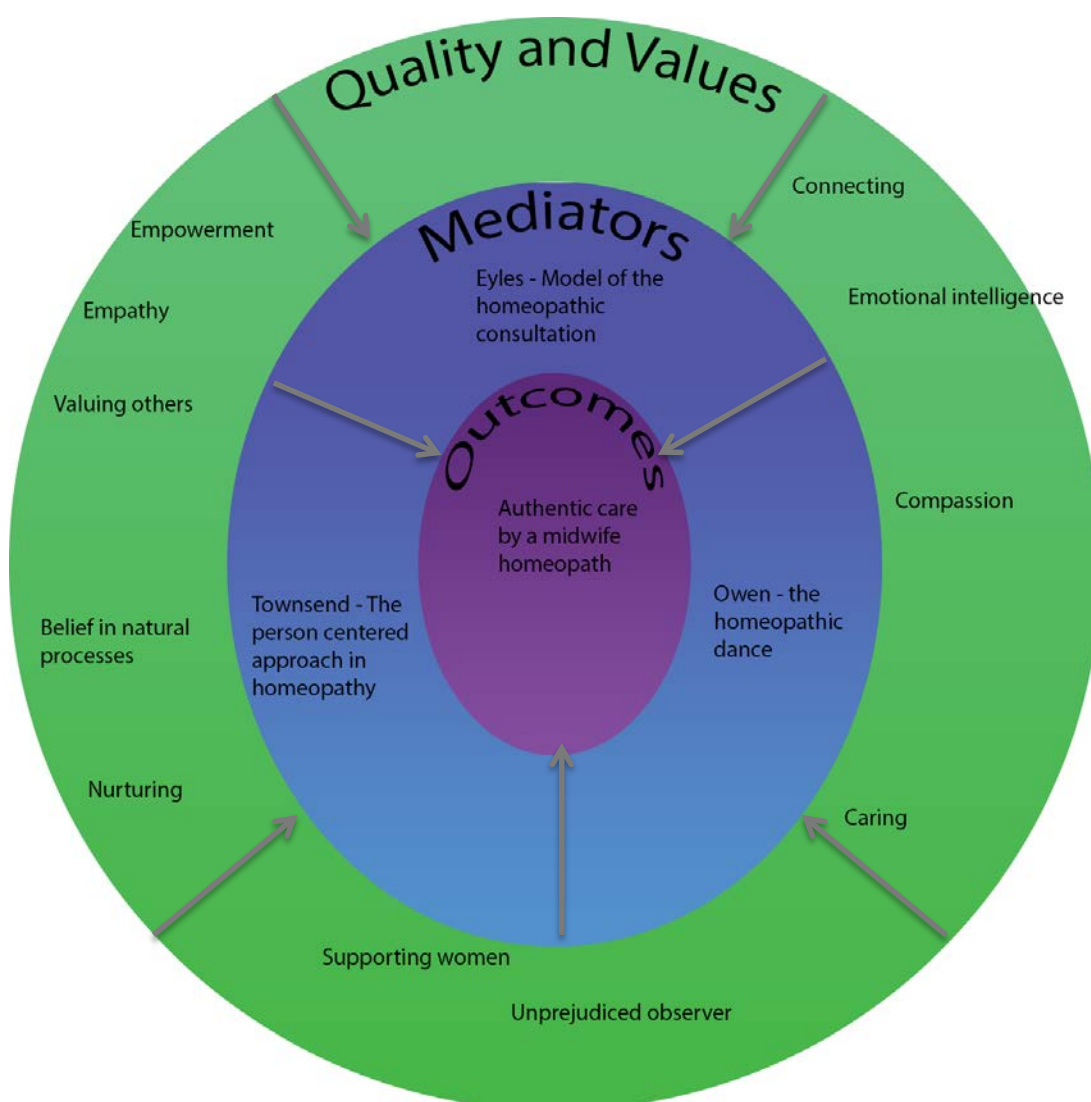
## **8.9 Synthesis of practice implications**

The diagram (fig. 7) featured overleaf sums up the hypothesis from this study. In the outer layer of the circle lie the qualities and values held by midwife homeopaths.

It is through a model of the therapeutic relationship in homeopathy as described by Eyles (2009), Owen (2007) and Townsend (2010) that the midwife homeopath is enabled to provide authentically based care to women.

Figure 7: Qualities, values and attitudes of midwife homeopaths

Diagram showing how the qualities, values and attitudes of midwife homeopaths are translated into the provision of authentically based care to women, their babies and families.



## 8.10 Conclusion

In my study those participants who remained as midwives passionately believed that they provided a high quality model of care for women, their babies and extended families. This remained so, despite the difficulties they perceived they had encountered. When talking about this care, they stated that whilst a good level of practical skill was essential, excellent care needed to include a therapeutic relationship between the midwife and her patients.

A possible explanation is that midwife homeopaths are authentic practitioners who have managed to re-engage with the social model of care that is entirely congruent with their values. This has been made possible by the very clear models of engagement with patients/clients that are characteristic in homeopathy. It may be that a direct link existed between the midwife homeopaths values and attributes, and the models of care used by them, and this in turn translated into how they cared for their patients/clients. It appears that midwives who became midwife homeopaths were able to make use of its philosophy of practice, as a way of legitimising their belief about the way midwifery should be practised. Homeopathy, not only because it values the individual but also because it has a philosophy and way of managing care mediated through its model of case taking, might result in the practitioner making meaningful '*connections*' with their patients/clients, and thus enhancing care.

The next chapter forms the discussion and conclusion. The strengths and limitations of the study are discussed and suggestions for future research identified.

## Chapter Nine - Discussion and Conclusions

### 9.1 Introduction

In reaching the conclusions of my study I return to my research title: '*Straddling paradigms: an interpretive hermeneutic exploration of the experience of midwives practising homeopathy*'. From the very start of my study it became apparent to me that there was a dissonance between health care rhetoric and the reality of health care on the ground, as reported in the popular press and as explained by the participants in my study. This included a relentless reporting of failures of care within the NHS and culminated in the damning Francis Report (2013, p.1).

Amongst a range of issues, the authors of the report noted the '*appalling care*' offered where staff treated '*patients and their families with indifference and a lack of basic kindness*'. Rather than being isolated incidents the findings stated that there was '*an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities*' which they believed rang throughout the health service.

In this context, my study commenced with an examination of the wider environment in which midwives work, together with an analysis of the implications of this. This allowed me to identify a number of complex and multi-factorial tensions in the NHS (see figure 8, p.282). This examination exposed the existence of a critical tension between the scientific-bureaucratic notions of guidelines and standards generated by managerialism and the EBM movement (Miles and Loughlin 2011); and the findings of Francis (2013) regarding what he believed was a grave lack of empathy and caring in the system. Further examination revealed that these tensions could be explained by extreme risk aversion, contextual factors and the rhetoric of '*ideal-type*' health care.

The research aimed to explore the experience of individuals who had chosen to become experts in two professional disciplines, one of which is framed in the current '*normal science*' of standard health care provision (Kuhn 1970): midwifery; and the other, homeopathy which tends to stand in opposition to these health care norms.

Three different, yet connected lenses were chosen to reflect my understanding and interpretation of the participants experiences. I used the first lens to frame the midwives narratives through the concept of '*metamorphosis*'. This resulted in a descriptive analysis of the personal and professional changes that occurred as the participants developed into midwife homeopaths.

The second lens framed the data using a Heideggerian analysis, illuminating their transformation into '*becoming*' authentic and autonomous practitioners. The final lens enabled an exploration of the impact engendered by this transition on the therapeutic relationship midwife homeopaths developed with the women and families in their care. The use of a range of different lenses allowed me to '*produce a bricolage, a complex, dense, reflexive, collage like creation that represents the researcher's images, understandings, and interpretations of the world or phenomenon under analysis*' (Denzin and Lincoln 1998, p.4).

In this final chapter, I assess the relevance of the study to midwives, mothers and their families, and healthcare providers. Recommendations for education, practice and research are outlined, prior to a consideration of the limitations of the study.



The midwives stories lie at the heart of the research. The participants were all aged in their 40's and 50's, and their midwifery training took place in the 1970's through to the early 1990's. Since qualifying they had seen many things impact their practice. Some changes came about from personal crises, whilst others were institutionally or societally driven. When this group of midwives started their careers, neoliberalism was in its very early stages and evidence-based medicine was only on the horizon. It was this combination of the personal and professional that led them to take up the practice of homeopathy.

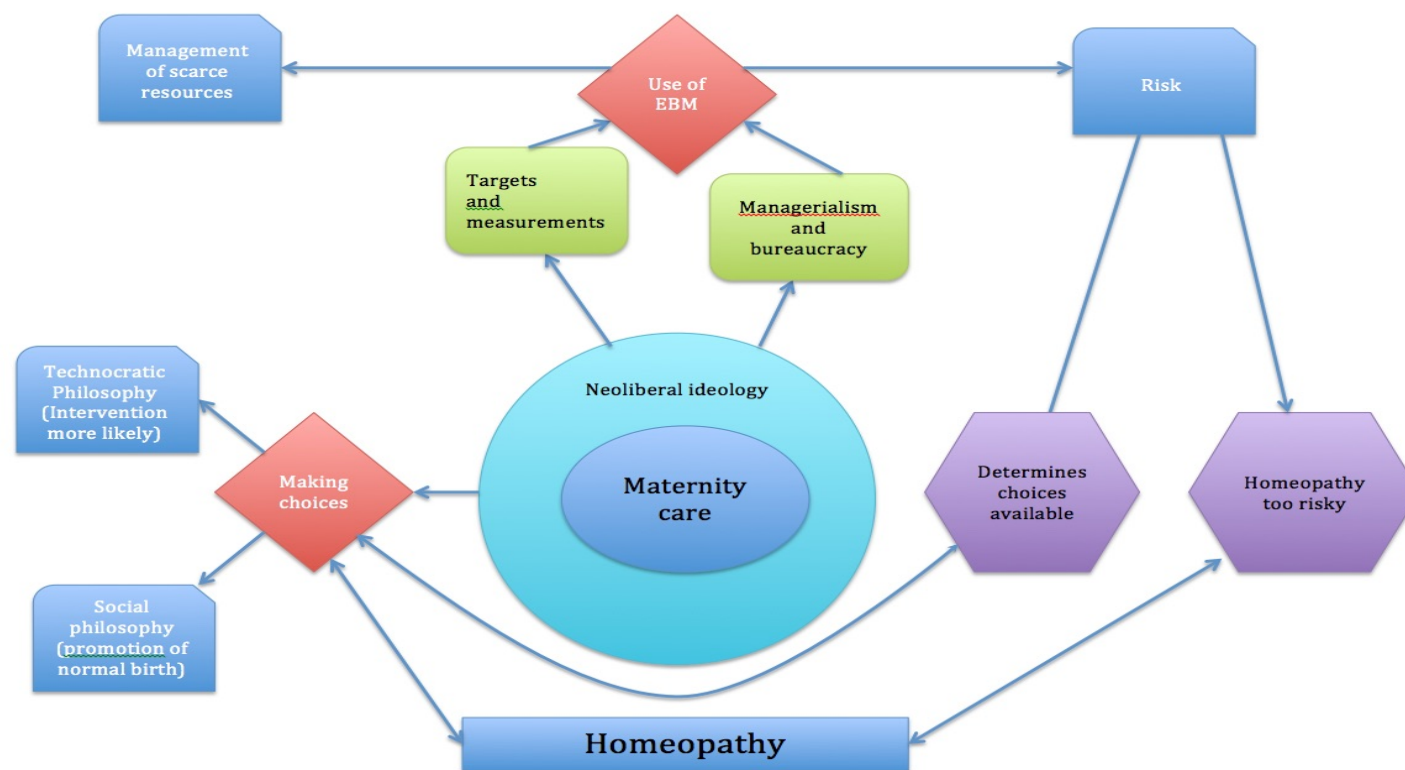


Figure 8: Diagram showing the tensions surrounding homeopathy and the NHS

The discussions in previous chapters concerning the complexity and tensions inherent within modern healthcare are depicted in Figure 8 (p.282). Over the preceding four decades healthcare had been subject to a huge amount of change. Initiated by Margaret Thatcher, the underpinning neoliberal ideology of the conservative government led to an increase in managerialism and bureaucracy in the NHS as well as an increased dependency on setting measurements and meeting targets. This was a fertile ground for the development and promotion of EBM and in turn EBP. In turn, this resulted in increased measurement and target setting for NHS institutions and personnel. Measurement contributed to the ability of the NHS and governments to determine risk, and as a consequence resources could be allocated in accordance with deemed effectiveness.

The existence of a neoliberal, consumerist ideology also allowed for the framing of choice in maternity care to emerge as a reasonable objective. In this context women were, in principle, encouraged to make choices about the place and type of birth experienced. In theory, this should have opened up a space for the midwives in the study to practise midwifery framed within the social model of care. Instead, this choice has been criticised for being essentially rhetorical, the reality experienced by women being very different and notions of risk supported by EBM and EBP reinforce this. Homeopathy despite its use by women, is deemed to be risky because of its perceived lack of evidence.

When I first started to examine the data from my study participants, I viewed their stories as a journey from midwife or homeopath to midwife homeopath. They started at point A and moved to point B. In fact, whilst they did '*journey*', the notion

failed to really capture the manner and extent of the changes they experienced along the way. On reading and rereading the data, over time, the concept of a metamorphosis emerged. As a consequence I began to examine their experience through the metaphor of '*metamorphosis*'. The participants changed through this period and emerged, in the majority of cases, as radically different people. In moving away from privileging the scientific, population based approach to healthcare they have moved towards privileging the individual. A consequent disconnect between the midwives and the institutions they worked for is revealed. The midwives who were not able to integrate their newly developed views about health made an authentic choice to leave the NHS, and half of the midwives in the study chose to do this. Those able to successfully navigate between personally held views and those of the organisation were able to remain as NHS midwives. They worked as integrated practitioners in a non-integrated system. All the participants remained as homeopaths regardless of their status as midwives

This metamorphosis can also be seen as the midwives '*becoming*' authentic. When seen through a Heideggerian lens, the midwives '*angst*' through illness is revealed, and this opens up a space in a clearing where their future possibilities are illuminated. Their history and their future coalesce in this moment of authentic choice. They do not all make the same choice however. In Heideggerian terms after their transformation the midwives chose not to return to the '*They-world*', but instead make authentic and autonomous decisions. In the initial stages of the analysis it appeared as though, only those who had made a resolute decision to leave the NHS were acting authentically. However on further immersion in the data it became evident that, leaving or remaining, all the participants had acted resolutely. Emily and Zoe were able to remain in a system that appeared to be

fundamentally opposed to their emergent authentic selves. This is in direct contrast to the type of care described and criticised more recently by Francis (2013).

Figure 8 also demonstrates how a mechanistic, Cartesian style of care, underpinned by an overarching institutional ideology of neoliberalism, in combination with a hierarchically formed EBM leads to a loss in recognising and working with the individual service user. This can occur when meeting targets becomes the primary focus of a service area. In contrast, midwives in this study operate within the social model, and possess an overriding philosophy about the importance of the whole person, and this can be seen through the third lens, the therapeutic relationship. The midwives told stories about how they engaged with mothers and families. They recognised that whilst they could not use homeopathic remedies in their NHS practise, they could use the values and skills they developed during their training and as homeopaths. They did this through acting with authenticity, and this meant they were predisposed to privilege the individual. The overriding philosophy of homeopathy, lying in its approach to the whole person leads to an understanding that a person is not defined by their illness or condition, but instead as an individual who is 'experiencing' an illness or condition. This is a fundamental difference in the approach and one that allows practitioners to '*connect*' to those individuals in their care. In their own view, the participant's engagement with the philosophy and principles of homeopathy led to their metamorphosis into authentic practitioners, able to provide high quality, effective, physical and emotional care to others.

A Heideggerian analysis has allowed me to proffer a hypothesis about the midwives transformation into authentic practitioners. The study, in exploring the world of

these midwife homeopaths, demonstrates how acting authentically allowed them to re-engage with, and value the therapeutic relationship as a fundamental element of their clinical practice. This study offers insight into a different way of understanding health, and provides valuable understanding into how practitioners respond when they feel they lack authenticity. Findings from the study highlight the need for practitioners to be able to offer authentic, compassionate care mediated by a clear philosophy of what it means to 'care' for others. This will allow the NHS and other healthcare providers, through their staff, to provide individual, person-centred care.

The NHS has, after the Francis report, publically recognised some of the reasons for its failure to deliver consistently good care and is providing guidance to institutions and practitioners. In responding to this the NHS has developed a vision and strategy around the '6 C's' (NHS 2014b). The '6 C's' represent the six fundamental values of care, compassion, competence, communication, courage and commitment. The strategy defines a number of objectives to enable the delivery of compassionate care in practice. These objectives include meeting the standards of the Nursing and Midwifery Council Code of Conduct (2008), the delivery of the principles and values of the NHS Constitution (2013) and the six core statements embedded in the Department of Health's National Nursing and Midwifery Strategy (2012). Whilst the Francis report has been welcomed; there are concerns about some potential dangers with the implementation of the recommendations. It is possible that in enacting them, the NHS may just create another level of bureaucracy using a '*top-down*' approach of meeting further targets. If the systems in place had encouraged the participants to provide authentic care those who left may not have done so. More recently, there have been calls to put appropriate systems in place to support staff and encourage high quality care. Were this to happen, this would result in a well-trained, experienced, motivated and

caring work force. It is possible that the implications of this study go beyond the NHS and the United Kingdom. Patient safety and the delivery of high quality care are a global concern.

## **9.2 Strengths and limitations of the study.**

The study contributes an increased understanding of the experience of midwives as they attempt to offer holistic, and individualised, authentically based care in the NHS. The strength of this study reveals how practitioners are able to find ways that enable them to be authentic in the face of institutional failings. It uses a thematic analysis, allowing the midwives stories to unfold. Seen through a Heideggerian hermeneutic phenomenology, a unique perspective about the importance of authenticity when providing care has been offered. The midwives were selected from a range of Trusts and had attended a number of different colleges of homeopathy.

A requirement when making an application for ethical approval is to cite how many interviews would take place. Guest *et al* (2006), in their article "*How many interviews are enough*", discuss how theoretical saturation has been used as the primary criteria for justifying sample size in qualitative research. To explore this, Guest *et al* (2006) conducted a study to explore the number of qualitative interviews required to ensure that data saturation had been achieved. They found that of the 36 codes developed in the study, 34 were developed after the first 6 interviews, and 35 after 12 interviews. They concluded that if the sample used had a high level of homogeneity, as was found in my study, then '*a sample of six interviews may be sufficient to enable development of meaningful themes and useful interpretations*' (Guest *et al* 2006 p.78). My sample was fairly homogenous, and although this

meant that a smaller number of participants could yield the data required (Guest *et al* 2006), there is also the possibility that there are midwife homeopaths in practice who had a different experience. The midwives in the study had trained as nurses before embarking on their midwifery training and no direct entry midwives were recruited. Participants were female midwives each with over 20 years midwifery experience. Consequently their early training and practice experience differed from more recently qualified midwives. When designing the study inclusion criteria were devised to encourage the participation of any midwife who had also undertaken professional training as a homeopath regardless of age or gender. Whilst it was possible that there were younger, or male midwife homeopaths in practice, my sample was consistent with the NMC 2008 estimation that two thirds of midwives were over the age of 40 with a quarter being over the age of 50 (NMC 2010). This reflects a similar profile to the Society of Homeopaths, where they found that 65% of their 1400 members were aged between 35 and 54 years of age and 81% were women (Society of Homeopaths 2006).

However, the notion of data saturation presents a number of difficulties. The first of these is that theoretical saturation is not a primary aim when conducting a phenomenological study (Ferguson *et al* 2010). The aim of my research is to develop an understanding of how this particular group of midwife homeopaths experienced their transition into midwife homeopaths, and the impact of this on their practice. It does not seek to answer questions on '*how much*' or '*how many*' participants experienced this phenomenon. Therefore, a purposive sampling technique was employed, and sampling decisions were made on asking myself whether or not the midwife had the experience to enable them to answer my research question. When reading about how to structure a phenomenological study, I found literature affirming that phenomenological studies can have a sample



as low as one, or as many as 300 or more, with Morse recommending around 6. Initially I chose to aim for 6-10 participants, as this I believed would provide me with sufficient high quality data. During the period of recruitment to the study it transpired that this group of participants could be considered as a '*hard to reach*' or '*hidden*' group (Guest *et al* 2006). Neither professional register keeps records on alternate qualifications, nor did snowball sampling reveal significant numbers of potential participants. After repeated attempts, including the use of snowball sampling, I was able to recruit seven midwives to the study.

Of the seven midwife homeopaths, one chose to withdraw from the study after being interviewed. The remaining interviews, ranging from 50-80 minutes provided a large volume of data. The participants had each received the study information sheet prior to deciding whether or not to take part in the study and so had already had the opportunity to think about their experience. As a result of this they felt comfortable being able to tell their stories freely and openly. Rich data is data that gets beneath the surface, and is focused and full of detail. I was seeking data that revealed the participants' thoughts, beliefs, feelings and actions as well as the context and structure of their lives (Charmaz 2014). The interviews proved to be an appropriate method of collecting this data.

Both a strength and limitation of the research concerns, me, as the researcher. As an involved researcher, I carry with me a set of beliefs and assumptions that can be identified in this research. However, a different researcher with a different set of beliefs and assumptions may have approached the research very differently.

### **9.3 Implications for practice**

The sample size is small and therefore I am unable to make any firm recommendations for practice. However the research does suggest the need for practitioners to be enabled to act with authenticity. This authenticity should be based on a set of coherent values that are mediated on caring for others. This would enable a health care professional to be given the space and opportunity to provide the high quality care identified as lacking in healthcare. Authentic practitioners would act autonomously and recognise their accountability. Health care practitioners should be encouraged to see and relate to people as individuals and not their health condition or illness. The training of healthcare practitioners ought, in addition to knowledge and skills, place greater importance on '*developing the practitioner*'.

Further evaluations of health care needs to adopt the mosaic of evidence approach. This way different types of evidence will each be able to make its own contribution to the whole.

### **9.4 Suggestions for future research.**

In making suggestions for future research I am minded to recommend further research examining the impact of the therapeutic relationship in midwifery on midwives and women. However, I would also make a recommendation that wider studies take place, and these could include an ethnographic study observing the therapeutic relationship of practitioners in NHS practice settings in combination with in-depth interviews. A qualitative study analysing how the current models of health care education impact on practitioner's views and beliefs about the importance of the therapeutic relationship would make a significant contribution to the knowledge

base in this subject area. I would also suggest that further research take place regarding midwifery education and awareness of CAM, the historical philosophies, benefits and risk. A final suggestion would be to examine the impact of the Francis Report and subsequent government responses on practitioner's capacity to act authentically and autonomously, and on the outcomes of any changes in this.

## Chapter Ten: Reflections and reflexivity

I opened my thesis with a description of how I came to choose to research this topic. Therefore I believe that it is only fitting that I conclude it by recounting my experience during the study.

### 10.1 Introduction

I want to start my account with a description of my introduction to reflective practice.

I had only recently been employed as course leader for the BSc (Hons)

Homeopathic Medicine. As described earlier my previous academic experience as an academic lawyer, was in a discipline that paid scant attention to reflective

practice. Looking back, I can see that it may have been considered a weakness rather than a skill that could strengthen a person's ability to practice. Ian

Townsend, a very good friend and colleague suggested that, as part of a course team, I should begin keeping a diary and engage in supervision. One element of this was to reflect on my teaching. The whole of the course team were involved in this practice, and our reflections were shared amongst us to enable us the creation of a cohesive unit. To begin with I protested strongly; as a child I never wanted to

keep a diary, and this continued throughout my life. However, he persisted and I started to keep a diary, but very sporadically. Although I consider myself to be reflective, it was not until I started this study that I began to understand the difference between being reflective and reflexive. Reflectivity and reflexivity are often conflated. Reflection is defined as where a person or practitioner learns:

*'from experience about themselves, their work, and the way they relate to home and work, significant others and wider society and culture.....It challenges assumptions, ideological illusions, damaging social and cultural biases, inequalities, and questions personal behaviours which perhaps silence the voices of others or otherwise marginalise them. (Bolton 2010)*

However, reflexivity goes beyond this. It requires that a person develop or find strategies that enable them to question their own belief structures, assumptions and attitudes and to understand these in relation to others. Sandelowski and Barroso (2002, p222) explain that:

*'Reflexivity is a hallmark of excellent qualitative research it entails the ability and willingness of researchers to acknowledge and take account of the many ways they themselves influence research findings and thus what comes to be accepted as knowledge. Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share.'*

Thus, when I revisit my written reflections during this study I do it with the recognition of the part I played in bringing it to fruition, and within this recognise how somebody else might have chosen to approach the topic very differently.

## **10.2 My experience of the study**

With this in mind, the story that follows is both reflective and reflexive. Like any study there were up's and downs, thrills and disappointments. At various times I considered '*bracketing*' and the effect its adoption might have on my study. This led to my exploration of IPA, which I later decided against (p. 164). According to Tufford and Newman (2010), bracketing is a way of managing the damaging effects of any preconceptions that might affect the research. The notion of bracketing was favoured by Husserl. Husserl wanted to look beyond our own constructions, preconceptions and assumptions so that the phenomenon itself could be clearly seen. When viewed from a Husserlian perspective our own constructions and assumptions get in the way of understanding phenomena. Heidegger disagreed

with this believing that an interpretive approach was needed to be able to understand a phenomenon. Instead his attitude was to value a persons' *'being in the world'*. Context and meaning are thus considered necessary to understanding. My own approach lies within this Heideggerian perspective. In a study where there was a focus on what it means to be authentic, I too, wanted to be authentic and the adoption of a Heideggerian approach encouraged me to value myself in the research.

By choosing not to bracket I considered my role in the interviews. I knew some of the participants but not all, however they all knew that I was a homeopath. This led to initial concerns about whether this would affect the validity of the data. In particular, I was concerned about whether they would tell me what they thought a homeopath would want to hear. However this concern was, in part, dispelled by using unstructured interviews so the participants could choose the content and direction of them. In case prompts were needed I created a few possible areas for discussion. These areas included:

*Why did you train as a homeopath?*

*Has the study of homeopathy impacted on your practice as a midwife?*

*If it has, how has your practice changed?*

*If it hasn't, why is this?*

Although recognising that this was not a therapeutic intervention, skills developed in homeopathic practice proved to be very useful. In homeopathy we *'take a 'case'* or *'interview'*, or as I like to call it, *'receive a case'*. During the initial phase of this *'receiving process'* we ask very few, open ended questions. We also adopt the role of the *'unprejudiced observer'*. Although I don't believe it is ever possible to be truly *'unprejudiced'*, it is still a condition I try to achieve in an interview. This is not the

same as '*bracketing*' however. Conway (2014), a homeopath, states that this requires the homeopath to be centred, still and to work in silence. In other words the homeopath creates a space that is not filled with '*noise, chatter, comments or even thoughts*'. It is in this space that the participant is invited to reveal their story.

My fore-understanding did not include an in-depth comprehension of the changes that happened to the participants. At the time of commencing the study I thought that when interviewing the participants I would find a discourse about the barriers midwives confronted when attempting to use homeopathy in their practice. Day (2012) states that all research interviews have '*power dilemmas*' (Day, 2012).

Hoffman (2007) suggests that the balance of power in interviews shifts from interviewer to interviewee and vice versa throughout the interview. It is argued that whilst the interviewer has the power to interpret and craft the stories, the interviewee has the power to choose if and how to answer the question, particularly in unstructured interviews such as my own. With this in mind, I was delighted by the interviewees' candour and willingness to share their experiences. They went into great detail about their experiences and how these had shaped them. Even having read articles about why nurses left the NHS, I wasn't expecting to hear such traumatic, heart-felt, personal narratives. I did struggle at times to remember that I was a researcher and not a homeopath. By not having the tools of my trade available to me I felt vulnerable, and afterwards I realised that it was similar experience to theirs, to feel that you can do something, but not being able to because it was not allowed, or it was inappropriate in that setting. My normal role when interviewing is of carer, responding when someone has been hurt or has mental or emotional symptoms.

I also realised that listening to '*real people*' narrate their own stories felt qualitatively different to reading the academic studies on the use of homeopathy in pregnancy and childbirth. When listening I felt I was listening to stories of personal courage as they become self-employed homeopaths, and it made me think about the fact that I had not had to make similar choices. Some of the participants had given up good careers that had once been fulfilling, whilst others had experienced changes within their personal lives. My transition into being a homeopath was very different. My own professional practice as an academic lawyer shared no overlap with homeopathy and whilst colleagues were interested they held no strong opinions about its effectiveness or efficacy. The stories led me to think about what it means to live an authentic life – and whether it needs to be one that is extra-ordinary. This group displayed this quality; they had each made that resolute decision that turned their lives upside down. At first I questioned myself about those participants that had remained in the NHS, had they settled for something less than being authentic. They had gone through the same homeopathy training, and shared similar experiences to those who felt that to be authentic they had to leave. I found this challenging, and asked myself whether this made them '*inauthentic*'. They appeared to be able to straddle the two practises, each rooted within a very different practice paradigm. I questioned whether this was because they had '*given up*' on their homeopathy. To understand their stories I needed time and space so that an understanding would reveal itself. Eventually I came to realise that the midwives who remained in the NHS became part midwife, part homeopath. They emerged from their transformation as people who became what I think of as '*thinkers*' not just '*do-ers*'.

At the same time, the midwives experiences led me towards reading phenomenology texts. To begin, I avoided this, and continued to read works by



Foucault, Meyer & Land, Alford, and Merleau-Ponty. However, I kept returning to Heidegger for an explanation of the phenomena I was seeing reflected in the transcripts. The more I read the more it seemed to me, to offer an explanation, not only of my approach to the study, but also in understanding more about the practice of homeopathy and around the transformation of the midwives. I found reading Heidegger difficult but the concepts surrounding what it means to be truly authentic really resonated with my own experiences. As the study continued it became clear to me that this was not a study about whether or not homeopathy is effective, but about the '*experiences*' of this group of midwives throughout their metamorphosis. It has captured why they chose to become homeopaths and the changes that occurred along the way, eventually culminating in what it means to be a midwife homeopath and the impact of this on the individual.

### **10.3 Conclusion**

Over such a long period of study it can be difficult to see the changes and learning that have taken place. It was only when reading the diary and revisiting my own struggles along the way that I can see the changes that have occurred. I have noticed a growing confidence in my work, and it is here that most changes have happened. I have absolutely loved the reading, and the revelation to my own outlook that Heidegger has brought to it. Although at times I have found the reading very dense, repeated reading more than repays the effort.

Above all, I remain grateful for the midwives being willing to talk to me and for the advice and guidance of all the people who have helped me in this process.

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## Appendices

## **Appendix 1: Alternative analytical frameworks**

### **Alternative analytical frameworks**

Before conceptualising the midwives narratives through the analytical lenses of metamorphosis, authenticity and the therapeutic relationship I explored a number of alternative frameworks. Whilst I chose not to make use of them for this study I have presented them below, explaining their relevance.

### **Threshold concepts**

The midwives in the story said they couldn't go back, and for Jessica this meant that she could no longer be a midwife.

*'why I wouldn't go back. I couldn't , I wouldn't want to , wouldn't say I couldn't, wouldn't want to look after women and give them conventional treatment , drugs things like that when I know how much better it could be for them using homeopathy'* Jessica (105-107)

Whilst Chloe was starting to resent her job after learning about the philosophy of homeopathy and left midwifery as soon after her homeopathy training as she was able,

*'I found it difficult and the more I learned about the philosophy, the more I hated my job'* Chloe (49-51)

These comments sparked my interest in asking what it was that had changed the midwives perspectives so much that it made them question their midwifery vocation.

The threshold concept emerged from a UK research project conducted by Erik Meyer and Ray Land (2003) examining the characteristics of strong learning and teaching environments in undergraduate learning. Meyer and Land purport that for every subject, there are concepts, the mastery of which provides the learner with a deeper grasp of the subject and without developing this mastery; the learner will never really fully understand the topic. Cousin (2006) when discussing how threshold concepts are recognised, states that when a threshold concept is grasped there is not only a conceptual shift but an ontological one, and the '*new understandings are assimilated as part of who we are, how we see and how we feel*' (Cousins 2006, p4). A threshold concept once learned is irreversible, although the learning can be refined or rejected for a rival understanding. Emily says of her own learning:

*'You can't ever unlearn what you have learned so you can't ever go back, you are always changing, so there has never been a point where I have thought this homeopathy is rubbish, it doesn't work I will just go back to being a midwife because you can't undo that and I don't think it anyway. Emily (302-305)*

Mastery of the concept also allows the learner to make connections in the subject that may be hidden to others without the same mastery. The threshold concept is usually one that is hard won in the first place and often involves types of '*troublesome knowledge*', that is '*that which appears counter-intuitive, alien (emanating from another culture or discourse), or seemingly incoherent*' (Meyer and Land 2003: 7).

The learning of a threshold concept means that the learner is suspended in a '*liminal space*' that has been described as being like that of an adolescent who is no longer a child and not yet an adult. It is a place of instability where the learner can hover between old and emergent understandings. This liminal state can involve identity shifts.

There is little research identifying those concepts in homeopathy that can be considered as '*threshold concepts*', although Lombaerts (2010) suggests that notions of the vital force, miasms, principles of ultra high dilutions and the unprejudiced observer could all be thought of as troublesome.

Meyer and Land (2003) state that one of the consequences of comprehending a threshold concept may include a transformed internal view of subject matter, subject landscape or even world view. Such a transformed view or landscape may represent how people '*think*' in a particular discipline or how they perceive, apprehend or experience particular phenomena within that discipline or more generally. Grace found this to be the case, and said that:

To me after doing homeopathy and really understanding the true nature of health and disease it has no credibility for me. Grace (161-163)

It is a reasonable presumption that midwives learning homeopathy have to engage with the principles of homeopathy, some of which, as already mentioned appear counter intuitive to the medical model (Montagnier, Aissa, Ferris *et al* 2009). This can be a difficult process both conceptually and emotionally, and once they grasp these concepts and work with them their ontology or even personal identity may change. It is this change that can lead to difficulties as they continue to work in the NHS.

Threshold concepts also sit very comfortably with the metaphor of this group of midwives metamorphosis. They move through the larval stages of growth and the desire to learn (eat) as much as they can about homeopathy, their liminal stage is the



cocoon stage where they are held in a space and can reflect and assimilate changes prior to emerging as a butterfly with a transformed ontology.

### **Structural Interests**

The second approach considered as a framework was that of '*Structural Interests*' developed by Robert Alford (1977). The theory of structural interests was initially utilised as a model to describe the local reform process in New York City (1975). It has since been developed as a method of exposing the structural interests that underpin political processes in health systems. It allows an analysis to take place that depicts the relationships between key groups (North and Peckham 2001). Alford stated that there were 3 groups; the professional monopolisers, the corporate rationalisers, and the community, each reflecting the dominant, challenging and repressed interests in health care. These groups are also to be found within the NHS. Stopp (2003) conducted a study, reviewing the availability of CAM in the NHS using Alford's theories and concluded that all the stakeholders in the NHS including the dominant, challenging and repressed groups were broadly in favour of the public sector providing and financing CAM services. Stopps' findings led her to conclude that the reductions in the provision of CAM were an unintended consequence of the transfer of primary care commissioning from General Practitioner Fund Holders (GPFH) to Primary Care Trusts (PCT's) where purchasing decisions were made collectively rather than by individual or small groups of General Practitioners. There was also a general move towards purchasing decisions being made using 'evidence based medicine'. The reliance placed on evidence based medicine by the last Labour government created philosophical and financial difficulties for CAM in having to provide the type of evidence required to conform to Evidence Based Medicine protocols (Stopp 2003).

This framework could if explored further provide some insight into the reasons why some of the midwives in the study felt marginalised and excluded. I chose not to take the enquiry in this direction as I felt that using a Heideggerian perspective would provide a richer, more detailed and more coherent explanation about the choices the midwives made.

**Appendix 2: Ethical approval letter (University of Central Lancashire).**

5 February 2009

Soo Downe, Jean Duckworth, Joy Duxbury, Kay Sheikh  
Public Health & Clinical Sciences  
University of Central Lancashire

Dear Soo/Jean/Joy/Kay

**Re: Faculty of Health Ethics Committee (FHEC) Application - (Proposal No. 320)**

The FHEC has granted approval of your proposal application 'Straddling paradigms: an interpretive phenomenological exploration of the experience and practice of midwife homeopaths' on the basis described in its 'Notes for Applicants'.

We shall e-mail you a copy of the end-of-project report form to complete within a month of the anticipated date of project completion you specified on your application form. This should be completed, within 3 months, to complete the ethics governance procedures or, alternatively, an amended end-of-project date forwarded to Research Office.

Yours sincerely

Damien McElvenny  
Chair  
**Faculty of Health Ethics Committee**

### **Appendix 3: Participant information sheet.**

## **Information Sheet for Participants**

***Straddling Paradigms: an interpretive phenomenological exploration of the experience and practice of midwife homeopaths.*** (An exploration and examination of the impact and implications of the study of homeopathy on a midwife's practice.)

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 and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. *Thank you for reading this.*

### **What is the purpose of the study?**

Midwifery is a dynamic profession, one example of this in recent years is the development of midwives interest in complementary and alternative therapies. This has in part been influenced by greater patient empowerment and self-determinism. There are many instances where midwives have trained in homeopathy. The study aims to examine why midwives choose to study homeopathy and to determine the implications this has for their practice of midwifery.

### **Why have I been chosen?**

You have been chosen because you are currently a midwife and member of a United Kingdom Register of Homeopaths. Your views on this matter are highly valued and we wish to know your opinions on your experiences to date on the impact of your homeopathy training on your midwifery practice.

### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to return an informed consent form. You are free to withdraw entirely from the project at any time without giving a reason. Additionally, once the interview has taken place, you may request that any part of the interview is not to be used in the research.

### **What will I be asked to do?**

Your participation in the study will involve an in-depth telephone interview lasting for approximately one hour. This would be arranged at a time convenient for you. You will be asked to discuss the reasons for training as a homeopath, and the impact of this study on your midwifery practice. The conversation will be audiotaped.

Once the interview has been completed it will be transcribed and the data will be coded, exploring common themes. Your experience will also be contrasted with the experiences of other midwives taking part in the study.

You may also be asked if you would be willing to take part in a further telephone interview exploring your response to a series of case studies.

### **What are the possible benefits of taking part?**

Your contribution will provide information about the impact of homeopathy study on your practice. Your participation is altruistic but you will have the satisfaction of knowing that the results of the study will provide new information that may be of benefit to the midwifery and homeopathy communities.

**Will my taking part in this study be kept confidential?**

If you consent to take part in the research all the information that is collected about you will be anonymised and kept strictly confidential. The PhD supervisors will be the only other individuals who have access to the interview data. Data stored will be maintained on password protected computers used only by the researcher and supervisors, in locked filing cabinets, in a secure place. A copy of the transcript for each interview will be archived at the University of Central Lancashire. During the writing up of the study some quotations may be used in the results section that you may recognise but these will not under normal circumstances be attributable to you. The tapes of the interviews will be kept for 5 years and then destroyed. Similarly, the transcript of the interviews will be kept for 5 years and then destroyed.

**What will happen to the results of the study?**

This study is being undertaken as part of an MPhil/PhD programme. In addition results may also be published in academic journals and/or presented at conferences. You will not be identified in any report or publication.

**Who is organising the research?**

The investigator in this project is an MPhil/PhD student at the University of Central Lancashire (UK) and the proposal for this research has been reviewed by the University's Faculty of Health Ethics Committee.

**Who can I contact for further information?**

If you would like to discuss any further information you can contact the investigator or supervising researcher

**Supervisor**

Professor Soo Downe  
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[JEDuckworth@uclan.ac.uk](mailto:JEDuckworth@uclan.ac.uk)

Thank you very much for considering taking part in this study.

## Appendix 4: Participant consent form

# CONSENT FORM

**Title of Project:** Straddling Paradigms: an interpretive phenomenological exploration of the experience and practice of midwife homeopaths.

Name of Researcher: Jean Duckworth

**Please initial box**

**1** I confirm that I have read and understood the information sheet for this study and have had the opportunity to ask questions and get further information

☐

**2** I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving any reason.

☐

**3** I give permission for my interview to be audio-taped and transcribed by the investigator

☐

**4** I agree to take part in the study.

☐

**5** I am happy to be approached for further consent if there is a wish to use quotes from me in publications which may identify me.

☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

1 for participant; 1 for researcher



## **Appendix 5: Schedule of questions**

### **Possible Questions**

*The interviews will be semi-structured and hence these questions are indicative only. It is anticipated that emerging themes from earlier interviews will form the basis of later interviews.*

Why did you train as a homeopath?

Has the study of homeopathy impacted on your practice as a midwife?

If it has, how has your practice changed?

If it hasn't, why is this?

## **Appendix 6: 6 C's of Compassionate Care**

## The 6Cs

### 1. Care

Care is our core business and that of our organisations and the care we deliver helps the individual person and improves the health of the whole community.

Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

### 2. Compassion

Compassion is how care is given through relationships based on empathy, respect and dignity.

It can also be described as intelligent kindness and is central to how people perceive their care.

### 3. Competence

Competence means all those in caring roles must have the ability to understand an individual's health and social needs.

It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

### 4. Communication

Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do.

It is essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.

### 5. Courage

Courage enables us to do the right thing for the people we care for, to speak up when we have concerns.

It means we have the personal strength and vision to innovate and to embrace new ways of working.

### 6. Commitment

A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients.

We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

## 5. Ensuring we have the right staff, with the right skills in the right place

### National Actions:

- Develop evidence based staffing levels for mental health, community, learning disability services and care and support
- Embed the 6Cs in all nursing and midwifery university education and training
- Value based recruitment and appraisal
- Effective training, recruitment and induction of support workers

### Local Actions:

- Boards sign off and publish evidence based staffing levels at least every 6 months, linked to quality of care and patient experience
- Providers to review Supervisory status for Ward Managers and Team Leaders

### Call to Actions:

- Deploy staff effectively and efficiently; identify the impact this has on the quality of care and the experience of the people in our care

## 6. Supporting positive staff experience

### National Actions:

- National scheme to recognise excellent implementation of 6Cs
- Plan to support care staff within the workplace
- Review implementation of the Cultural Barometer once pilots have taken place
- Evidence based good practice for clinical placements of students, preceptorship and supervision
- Review the 'Image of Nursing' work and develop actions

### Local Actions:

- Strategies to secure meaningful staff engagement
- Implement the Friends and Family Test for staff
- Commissioners to ensure locally agreed targets to deliver high quality appraisals for their staff

### Call to Actions:

- Commit to working with local employers to improve experience in the work place

## Our Culture of Compassionate Care



## The Next Steps

To see the latest information about the implementation of the Vision & Strategy for Nurses, Midwives and Care Staff please visit: [www.commissioningboard.nhs.uk/nursingvision](http://www.commissioningboard.nhs.uk/nursingvision)

## Exec Summary

To be a nurse, a midwife or member of care staff is an extraordinary role. What we do every day has a deep importance. We are at the heart of how people in this country keep themselves independent, healthy and well for longer.

We help people to recover from illness, and support people in living with illness. We provide care and comfort when people's lives are coming to an end. The compassion and humanity we show shapes the culture of our health service and our care and support system.

We care for everyone, from the joy at the beginning of new life to the sadness at its end. We do so in the privacy of people's homes, in the local surgery, in the community, in care homes, in hospices and in hospitals. We support the people in our care and their families when they are at their most vulnerable and when clinical expertise, care and compassion matter most.

But there are big challenges. People also encounter care that falls short of what they have a right to expect, sometimes by a long way. We know we miss too many opportunities to support people to keep well, connected and healthy. Society and the health, care and support system is changing fast, and we will need to adapt in order to prosper and to continue to care for people well.



We acknowledge this and our professional commitment and values drive our determination to tackle these issues. We all joined our professions to make a difference. We have the potential to transform the care, advice and support that people receive from us.

We must seize this opportunity to create a future where people are placed at the heart of care and are treated with compassion, dignity and respect by skilled staff who have the competence and time to care, a future where the unbounded potential of our professions to provide compassionate care, promote independence, health and well-being is properly unleashed. This is our vision, and we have developed a strategy with you to make it a reality.

## The Vision and Strategy for Nurses, Midwives and Care Staff The 6 Areas of Action

### 1. Helping people to stay independent, maximising well-being and improving health outcomes

#### National Actions:

- Policy and programmes for:
  - Making every contact count
  - Maximising the leadership role of SCPHN
  - The public health role of midwives
  - Health visitor and school nursing plans
  - Dementia Challenge
  - 'No health without Mental Health'
- Developing accessible evidence based on NICE guidance
- Actively engaging across sectors, leading work effectively, integrating health, care and support

#### Local Actions:

- Make 'every contact count'
- Support nurses and midwives to maximise their contribution to the 'Dementia Challenge'
- Ensure practice is supported by appropriate technology

#### Call to Actions:

- Develop skills as 'health promoting practitioners' making every contact count

### 2. Working with people to provide a positive experience of care

#### National Actions:

- Provide rapid feedback from patients to build a rich picture of the 6Cs in action
- Support local services to seek the views of the most vulnerable
- Use feedback to improve the reported experiences of patients
- Identify strong patient experience measures that can be used between settings and sectors

#### Local Actions:

- Support the roll out of the Family and Friends test
- Rollout of the public reporting of pressure ulcers, falls, patient and staff experience and Safety Thermometer

#### Call to Actions:

- Actively listen to, seek out and act on patient and carer feedback, identifying any themes or issues and ensuring the patient and carer voice is heard



### 3. Delivering high quality care and measuring impact

#### National Actions:

- Publish 'High Quality Care Metrics for Nursing' by the National Nursing Research Unit
- Identification of metrics and indicators, which reflect compassion and effective care
- Development of the Safety Thermometer in mental health, learning disability, children and young people
- Publish information that identifies the quality of care and informs patients and the public

#### Local Actions:

- Publish & discuss quality metrics and outcomes at each Board meeting.
- Enable staff to gain knowledge and skills to interpret data.
- Ensure measurement and data collection is effective and simple.

#### Call to Actions:

- Support the measurement of care to learn, improve and highlight the positive impact on the people cared for

### 4. Building and strengthening leadership

#### National Actions:

- Develop a set of tools that enable organisations to measure their culture
- New leadership programme for ward managers, team leaders and nursing directors based on values and behaviours of the 6Cs
- DH will lead work to implement and embed the Leadership Qualities Framework for Adult Social Care and roll this out

#### Local Actions:

- Providers undertake a review of their organisational culture and publish the results
- Providers review options for introducing ward managers and team leaders supervisory status into their staffing structure

#### Call to Actions:

- See ourselves as leaders in the care setting and role model the 6Cs in our everyday care of patients



## Appendix 7: Literature search document

1	2	3	4	5	6	7
Database	No of hits	Author, date	Provides data on pregnancy, homeopathy, homeopathic, intrapartum, postnatal, postpartum (Y/N)	Provides quant data (Y/N)	Provides qual. Data (Y/N)	Notes

## Appendix 8: CASP Example



## 11 questions to help you make sense of a trial

### How to use this appraisal tool

Three broad issues need to be considered when appraising the report of a randomised controlled trial:

- Are the results of the trial valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 11 questions on the following pages are designed to help you think about these issues systematically.

The first two questions are screening questions and can be answered quickly. If the answer to both is **yes**, it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a **yes**, **no** or **can't tell** to most of the questions. A number of prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

There will not be time in the small groups to answer them all in detail!

**These checklists were designed to be used as educational tools as part of a workshop**

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Darfman et al (1987)  
Homeopathic preparation for labour: two fold experiment  
Comparing a less widely known therapy with a placebo.

### (A) Are the results of the trial valid?

#### Screening Questions

1. Did the trial address a clearly focused issue?



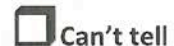
Consider: An issue can be 'focused' in terms of

- The population studied
- The intervention given
- The comparator given
- The outcomes considered

No of dyspnoeas  
+ length of labour between  
2 groups of pregnant women

no explanation of why h<sub>2</sub> remedies

2. Was the assignment of patients to treatments randomised?



Consider:

- How was this carried out, some methods may produce broken allocation concealment
- Was the allocation concealed from researchers?

Double blind stated but  
insufficient detail about the  
process.

Is it worth continuing?





Detailed questions

**3. Were patients, health workers and study personnel blinded?**

☒ Yes

☐ Can't tell

☐ No

Consider:

- Health workers could be; clinicians, nurses etc
- Study personnel – especially outcome assessors

**4. Were the groups similar at the start of the trial?**

☒ Yes

☐ Can't tell

☐ No

Consider: Look at

- Other factors that might affect the outcome such as age, sex, social class, these may be called baseline characteristics

*Groups were undifferentiated.  
demographic data was not  
recorded.*

**5. Aside from the experimental intervention, were the groups treated equally?**

☒ Yes

☐ Can't tell

☐ No

6. Were all of the patients who entered the trial properly accounted for at its conclusion?

☐ Yes ☒ Can't tell ☒ No

Consider:

- Was the trial stopped early?
- Were patients analysed in the groups to which they were randomised?

Attrition numbers not available nor are original numbers of women assigned because of the treatment groups.

## (B) What are the results?

7. How large was the treatment effect?

Consider:

- What outcomes were measured?
- Is the primary outcome clearly specified?
- What results were found for each outcome?
- Is there evidence of selective reporting of outcomes? *no*

Influence of the treatment on duration of labour

Influence of the treatment on number of dystocias

Results not detailed sufficiently

no power calculations shown

8. How precise was the estimate of the treatment effect?

Consider:

- What are the confidence limits?
- Were they statistically significant?

Statistical significance of homeopathy group effect ( $P < 0.001$ )

Women on placebo had deliveries that corresponded to normal expectations - (however this

Study mentions chi-square & Paired t test (quant) but the information does not show the results of this.

## (C) Will the results help locally?

9. Can the results be applied in your context?  
(or to the local population?)

☒ Yes ☒ Can't tell ☐ No

Consider:

- Do you have reason to believe that your population of interest is different to that in the trial
- If so, in what way?

Treatment was given to all women in 9th month of pregnancy regardless of age or number of previous pregnancies.  
Excluded - women with previous obstetrical complications

10. Were all clinically important outcomes considered?

☒ Yes ☐ Can't tell ☐ No

Consider:

- Is there other information you would like to have seen?
- Was the need for this trial clearly described?

patient satisfaction

11. Are the benefits worth the harms and costs?

☒ Yes ☐ Can't tell ☐ No

Consider:

- Even if this is not addressed by the trial, what do you think?

## Appendix 9: Example of interview data

**Zoe**

I think one of the biggest barriers to using homeopathy that we have are the NICE guidelines because the NICE guidelines categorically state that it cannot be used and if you hang on I will get you the one on interpartum care. I will read it to you. The difficulty is that all the trusts now because of their insurance they have to comply with the CNST (the clinical negligence scheme of the trust) and the CNST base all their assessments on the policies and procedures which have to follow NICE, so in order to be able to pass anything policies and procedures have to follow NICE and NICE has a section in their guidance.... So that is a huge barrier to get over... in [redacted] they were very open to women using homeopathy but the way they got round it was that the midwives used to refer to me in my private clinic and so get round it and the guidelines said that a midwife could support a womans choice as long as she was independently insured and a registered practitioner. Whether that will have changed with these new guidelines I can't tell you as I am not there. It categorically states that, unless it is done out of work.

Can't use lavender oil, nothing like that. Women come in with their homeopathy kits absolutely no problem whatsoever, and I can say to women that have their kits, you can read your labels and maybe look at this remedy or look at that remedy but I couldn't say to her take this, or take that. It is about management of risk and following guidelines.

We are autonomous practitioners so long as we follow guidelines CNST it is prescriptive. We really do have to follow what is said, we can say, we haven't followed this because and give a reason ie. Where we haven't followed a guideline but you have to have enough reason to do that to stand up in a court of law and say well this is what I have done. Say I said to someone, well OK don't go along with having this let me give you this instead and then they have a post partum haemorrhage for instance management of the 3<sup>rd</sup> stage then you know because I haven't followed guidelines I could lose my registration. It comes from clinical governance.

The women just approach me, at work but they can only see me out of work and that was the thing at [redacted]. Midwives are able to refer to me, and people just ask me about it, but to be honest I don't do a lot of homeopathy now, it is a completely swamped market up here, absolutely, and everyone is very covetous of their patch and their bit and they don't want anyone new.

So I think that comes really with a lot of it with what you can and can't do. A lot of people come into our hospital with their kits and I think I really want to tell them how to use this kit. because they are not particularly using it that well, and I want to tell them how to do it, but while I am working as a midwife I have to have my boundaries in place and whilst I can suggest 'have you thought about maybe reading that one, it is difficult. I think that you can practice midwifery holistically, you can do that, and that is where you become a practitioner in your own right, because you can support people in a holistic way and follow guidelines and protocols.

I don't think you need to give up midwifery, you see ie. If I give you a scenario of something that happened not that long ago. A young girl came to us from a midwifery led unit because she was post-mature, she actually went into labour spontaneously so didn't need any induction but she was within then a consultant led unit and she brought along a friend to be her birth partner, so she came across to the ward and we discussed the sort of things that she preferred for her birth and enough so that I could write a plan on what she preferred. She went into a room; we made the lights dim, got baby clothes out so she had something to focus on, trying to think what was going through my mind with her? She had quite a problematic history really, but we looked at that, we did a lot of talking, allowed them to talk whenever they wanted. I went in only when I had to do what I had to like listen to the baby, do her blood pressure, do her pulse whatever and stayed and chatted when she wanted to and relax when she didn't want to, and she progressed beautifully in labour and had a wonderful normal delivery with a baby that was actually quite ill, and why the baby was ill we don't really know, we know that the baby had some kind of infection for some reason, but we don't where it came from, the baby and mum had to be transferred to a neonatal intensive care unit, but she came back to me only a couple of weeks ago brought the baby, brought us lots of gifts and goodies and they are doing a sponsored bike ride because even though the baby was ill she felt that the experience was fantastic, as what happened, the support, everything. The baby was fine.

To me that was providing holistic care within a situation that was quite difficult. Other things that you can do, we have quite a lot of young girls that are pregnant and a lot of social deprivation and when people are coming in in early labour and very upset and not coping you can do things like pull out sofa beds and allow the partner and them to be together, and put the lights out and just say if they are in early labour, ring me if you need me, but they are

under the umbrella of them feeling safe. You can move your practice in those sorts of ways that is not a problem.

## **Jessica**

Vision of midwifery now? Nothing like it was 20 years ago when I started and they say it is very patient centred and they do try, do try to make it client orientated, but we have long gone away from looking after each other. We don't, nobody kind of works, no team work going on now, they think they work as a team, but everybody is out for watching themselves all the time, some of that is litigation and things which is much greater than it ever was, but some of that is the whole management structure, they are quite business orientated rather than, but I don't think that framework works within health care services, I don't think that, I realise you have to run it as a business but i don't think that you can bring to it the same strategies as you can to a management style or work place elsewhere, it is not like that with the structure of the NHS and you have to realise that you have to have enough Indians to make it work and not to have too many chiefs in at the top end, which is definitely the way it has all gone wrong at the minute, just not enough staff even when stressed, not good really compared with when I started it was great everybody looked out for each other, you know you longed to go every day, nobody was complaining, nobody was moaning about each other, or everybody just helped each other out and always the women were at the centre whether you call it patient centred or women centred, the women and their babies and families were always at the forefront of our practice irrespective of what they wanted to call it and I think it worked better then than it does now really.

## **Grace**

I suppose I had to keep midwifery and homeopathy very separate because the community midwife in particular you are delivering holistic care more so than if you were in a hospital setting so I was a community midwife and predominantly we had to go in and do different things but it was a bit frustrating I would say because I knew and could see that a lot could be done but my hands were tied so other than saying perhaps go to parentcraft classes and things like that. So there was a lot of education going on and you could say take a bit of arnica but really I wasn't allowed to.

Had to keep it separate as I would have been disciplined and the example is that during that period of course my manager ringing me up at 8 o'clock in the morning to say I want you to come into the office pronto and when I got there her words were 'I want you to come into the office to see me please it is over something you have prescribed' my heart stopped thinking oh my god! What have I said and done, which wouldn't have been much because knowing the position because they hadn't got a holistics policy or anything in place you see which they have now but at the time they hadn't, and she didn't tell me what it was of course, and I had to go there in anticipation of what on earth are they going to throw at me now, to find I had written chamomile tea on a bit of paper and it was that bad, and when I looked at it I nearly laughed, it was chamomile tea and you can buy it from a supermarket and she didn't kind of, and all she said was this has been reported because this particular woman had been admitted to hospital on the antenatal ward so this bit of paper had fluttered out of her notes and this particular midwife had gone marching down to the office with it.

My values changed as a result of studying homeopathy. Because it is based on natural laws, because the research hasn't changed in homeopathy in 200 years, based on truth, whereas today's bit of research in the science world is ok today but will be discredited tomorrow,. I think the allopathic method and model of healthcare have no foundation, it has no real foundations and that is why it is here today and gone tomorrow. You know one day it is a panacea and the next day it is positively dangerous. The fact that this vaccine given to my daughter and she had 4 or 5 courses and now it has been completely banned and withdrawn and it creates aplastic anaemia, it is like that kind of thing. To me after doing homeopathy and really understanding the true nature of health and disease it has no credibility for me.

I almost felt like when I was in that work situation I had to really watch myself, I couldn't leave any 'I' undotted or any 't' uncrossed in my practice and I almost felt like it was a bit of a waiting game for me to make a mistake and slip up so then they could get rid, as this person was not doing what everyone else was doing. I was going against the grain, that is what it felt like, I don't know if it was like that, but the chamomile tea incident didn't help, to be pulled up for something as ridiculous as that, I suppose compounded the feeling that I had to

watch my back unfortunately that is how it was. That was at management level, my direct manager. But she was only following instructions, it must have been discussed, for a midwife from the wards to scuttle down to the offices to complain about it and take it in there there must have been some discussion amongst the managers, it would not have been just here decision and I feel perhaps, I can still see her face now and I think she was perhaps under a bit of duress. I think she herself was told to bring me in.

They say we are autonomous that is the other point, but also the woman is supposed to have free choice and supposed to be in charge of her own body and birthing process and she is not. We used to teach that as community midwives and empower them to go into hospital and have it completely stripped away, they become completely overridden by the medical model. As soon as they were in that environment, they had a monitor strapped on you and if you weren't progressing within the 4 hours, or the 6 hours whatever, then they would start to intervene.

When I was there they were examined vaginally every 4 hours if it was a spontaneous labour, if it was an augmented or induced labour then they were examined every 2 hours. If you got an epidural it was definitely every 2 hours.

I don't think that it is impossible for homeopathy and midwifery to co-exist, but unfortunately it is the political correctness, it is the political agendas and the fear. There is a lot of fear attached to it unfortunately, all the midwives do things not because they feel intuitively it is the right thing to do but because they are fearful of their jobs, they are fearful of being sued, of being on the coroners carpet. They are practicing defensively, most definitely and that causes a lot of frustration for the midwives that truly want to just be with woman, at the end of the day midwives are about being with woman and just go through that natural birth but you are not allowed to do it unfortunately and if you do then watch your back.

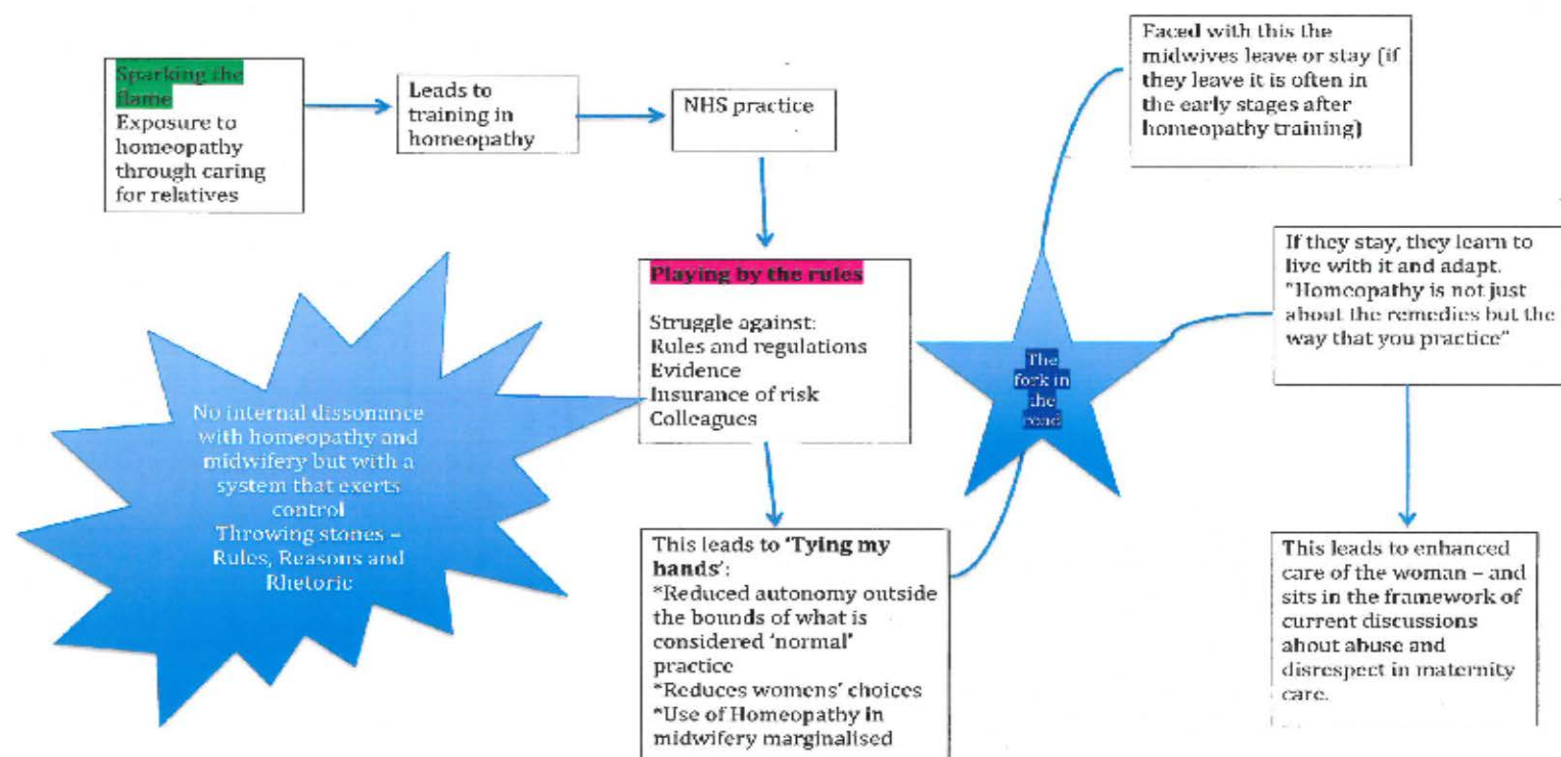
Everyone is doing what is perceived to be 'doing the right thing' in the 'right way' in the 'right order' because if they don't they are going to get slated and it is also fear based around



litigation and they are all terrified. You know my record keeping as a homeopath is extensive because of my training in midwifery, you know you write everything down, that's a legacy, it isn't a bad thing but they are doing it because they are scared of missing anything out just in case.

It is a shame, it really is a shame, people say to me how could you bear to leave it, it is like gosh, if you could just be a midwife and get on with it it would be absolutely fine but it is all the stuff that goes with it. It is a real, real shame, once that medical model comes in and research based evidence which is discredited the next day and something else.

## Appendix 10: Overview of themes



## Appendix 11: Relationship of themes to Heideggerian concepts

Theme	Heidegger
<b><i>Metamorphosis</i></b>	
<b>Blissful innocence</b> "Before" Loved it Longed to go	The clearing Inauthenticity?
<b>From a little spark may burst a flame</b> Who am I: just a nurse and midwife Hatching Wanting more	Susceptibility to the call Illumination The mood Unconcealment Concern (Care)
<b>Cocooning</b> Changing Curiosity of others Feeling unprotected "Watching me" Working around it Tying my hands (autonomy) Speaking only when needed	Conforming 'mineness' anxiety 'the they' free will 'losing myself'
<b>From Cocoon forth a butterfly</b> Homeopathy and midwifery – It's the way that you practise Putting something back	Authenticity Tools Ready to hand