

# 'nesting' and 'matrescence' as a birthing strategy



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Critique of Walsh (2006) “ ‘ Nesting’ and ‘ matrescence’ as distinctive features of a free-standing birth centre in the UK.

## Introduction

The provision of evidence-based midwifery care in the current UK maternity care setting is of high priority (Rosswurm and Larrabee, 1999). According to Kitson et al (2000) the implementation of research-derived evidence into clinical practice is mediated by the relationship between the attributes of the research in question, including the type and nature of the research evidence and its rigour and perceived quality; the clinical context or setting within which the research is applied; and the process of implementation and its effects on practice. Research evidence can inform individual aspects of midwifery care, midwives' attitudes and knowledge, or even the design and development of midwifery services. While for many midwives and other healthcare practitioners there can be ongoing challenges in the practical integration of research evidence into their work and professional role (Rosswurm and Larrabee, 1999), the value of research still lies in its rigour, usefulness and the specificity of findings (Stetler et al, 1998). For midwives, use of research evidence also means they can better support women to make informed choices (Magill-Cuerdon, 2006), particularly about place of birth, whilst keeping up to date (NMC, 2004).

This essay addresses the critique of a qualitative research study focusing on elements of birth centre midwifery care. Birth centres have emerged as a significant driver within the UK maternity model for bringing about better client satisfaction, better clinical outcomes and more alignment with

normality in midwifery. They also represent the emergence of policy which is responsive to some aspects of women's (and midwives') choices (Beake and Bick, 2007).

The articles were critiqued using a framework derived from the work of Rees (2003), and Cluett and Bluff (2003), due to their familiarity to the author and their ease of use. Both authors have a midwifery orientation, and while this critique has been informed by a range of nursing, midwifery and general research sources, it is good to retain a midwifery orientation for the process itself.

## Critique

### Title, Authors and Focus

The title of the study is clear and relates to the findings of the research and its focus on birth centre practice within the UK locality and maternity services paradigm. However, it does not refer to the nature of the research, which would have allowed the reader to immediately identify the underpinning research paradigm. The author is a Senior Lecturer in Midwifery within the UK, within a Midwifery Research Unit. It would also have been useful to know what involvement the author might have had in the unit and how specialist their knowledge of the research location was, to judge, for example, if there is any potential for bias (Polit and Hungler, 1995).

## Literature Review

The literature review is placed within the *Introduction* section of the paper, and presents both a rationale for the research and a placement within the

historical development of policy and practice. The nature of the review here firmly places the paper within a midwifery paradigm by critiquing historical applications of evidence within quantitative or scientific paradigms, which focus on pathology (Walsh, 2006). Conversely, theorists define the UK maternity services spectrum as being founded upon an holistic paradigm promoting normality, natural birth, choice, control and client-centred care (Beake and Bick, 2007). Walsh (2006) orients the discussion towards international issues about intervention rates, and links the discussion to pace of birth. However, apart from this, there is very little critical evaluation of existing research within the topic area; rather the author refers to an earlier study to which he contributed evaluating quantitative research studies about free-standing birth centres (Walsh, 2006). The author also uses this section of the paper to define some terms and some of the focus of the paper. A more detailed research critique would have been appropriate here (Baker, 2006; Cutcliffe and McKenna, 1999; Gerrish and Lacey, 2006; Holliday, 2002).

### Research Methodology

The author is explicit about having a qualitative approach, namely methodology, which is suitable for answering their research question (Walsh, 2006). The stated aim of the research “ was to explore the culture, beliefs, value, customs and practices around the birth process within an FSBC” (Walsh, 2006 p 229). According to Cutcliffe and McKenna (1999) qualitative research methodologies can attempt to answer questions about clinical practice which may not be adequately addressed by quantitative research approaches. Ethnography is an established methodology for this kind of

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research, particularly relating to birth setting and to midwifery centred care, all well aligned with qualitative models (Rees, 2003) and theory generating research (Parahoo, 2006). The usefulness of research studies such as this may be linked to their 'fit' with the issues concerned, and also with how detailed and rich (not to mention informative) the data derived are (Kearney, 2001). Such research also has the advantage of being more client-oriented (Parahoo, 2006). The methodology itself is outlined clearly and certainly suggests not only a deep grasp of the true meaning of ethnography but also the kind of depth of data it will produce (Baker, 2006).

## Sample

The author defines clearly the setting of the research, which is appropriate for an ethnographic study (Goulding, 2005), and defines the sample as comprising 15 midwives, 10 maternity care assistant (all the clinical staff working at the centre) (a purposive sample) and 30 women who agreed to be interviewed of which five allowed observation of their care (Walsh, 2006). The latter is described as an opportunistic sample (Walsh, 2006), which is similar to a convenience sample and is the kind of sample most commonly required for this kind of research (Wilkinson, 2000). There is no detail provided about how this sample was recruited, and so it cannot be judged whether or not this was done ethically or if any coercion was involved (Rees, 2003). There are no details given about the types of participants, or any demographic information which might enhance transparency and allow the reader to evaluate the transferability of these findings (Grix, 2004). While sample size is not usually of issue in qualitative research (Rees, 2003), and in particular, in ethnographic research (Devane et al, 2004; Hicks, 1996), as <https://assignbuster.com/nesting-and-matrescence-as-a-birthing-strategy/>

it is the richness of the data which is most significant (Hek and Moule, 2006), the sample size does seem to be adequate, particularly when the timescale and span of the research is considered.

### Ethical Considerations

Some attention is paid to ethics, in that access was requested and afforded by the local PCT who owned the building, and permission was secured from the hospital that employed the staff (Walsh, 2006). Ethics somittee was granted, and all participants provided “ informed written consent” (Walsh, 2006 p 229). Again, more detail here would have allowed the reader to evaluate the nature of the information and consent, and any other ethical issues there might have been in the research process (Austin, 2001). Ethical issues should be of primary importance in carrying out research of this nature, particularly in observing women during the time of birth, when they are not only particularly vulnerable but also particularly exposed (Austin, 2001). Vulnerability of subjects should be considered in designing clinical research (RCN, 2004). Some caution is needed over understanding the kinds of women recruited to the study and their level of vulnerability, for example (Rees, 2003).

A slightly more critical view of the ethical dimensions of this paper would have been useful (Cooper, 2006). For example, while ethics committees of fundamental importance in research governance and have a significant responsibility for the protection of patients and participants (Cooper, 2006), this does not mean that they can ensure true informed consent is given and has continued to be given throughout the duration of the study. The

Nuremburg Code (1949) underlines the need for voluntary consent, but could there have been any sense of obligation on the part of the research participants to take part? The Nuremburg Code (1949) further places responsibility for determining the quality and nature of the consent upon each individual person who initiates, directs or engages in the research, and so this author would question whether or not having all the birth unit staff involved in the study might have introduced some pressure on women to participate. Hollway and Jefferson (2000) describe consent as a continual understanding of the implications of the research for the participant. There is no indication of how this has been addressed here.

### Data Collection and Analysis

Data collection is dealt with as briefly as the sample, analysis and literature review are treated. The author carried out observation followed by follow up interviews, taking field recordings (audio) which were transcribed the next day, and interviews with women, midwives and MCAs, all of which were audio recorded and transcribed (Walsh, 2006). This kind of data collection is suited to the research design (Moore, 2006; Easton et al, 2000).

Walsh (2006) describes the analytical process as 'thematic analysis' (p 230), using line by line coding which again is an established process for analysing qualitative textual data (Goulding, 2005; Holloway and Jefferson, 2000; Rees, 2003). The thematic analysis process is outlined, and one example of how the researcher arrived at the themes and meanings is provided, which enhances transparency and auditability (Cluett and Bluff, 2006). The author

also discusses the process with reference to other literature. However, more detail here would have enhanced this section (Easton et al, 2006).

## Findings

As is fitting for a qualitative paper, the findings are discussed in some detail, under sub-headings which clearly signpost the discussion for the reader and make it easy to read and assimilate the information (Baker, 2006). The author also includes quotes from the textual data to exemplify the discussion (Rees, 2003). The findings are commented upon throughout, and there is an extension exploration of each theme. The themes were:

- The turn to birth environment and setting
- Affect of the first visit
- Nesting responses
- Vicarious nesting
- Care as mothering

## Discussion and Implications for Practice

The findings from this paper have clear implications for the understanding of the design and provision of birth locations within the UK maternity services. They also have significance for understanding the nature of midwifery practice, particularly within such a setting. The 'human' side of caring was evident, from the behaviours of staff in making the environment positive and supportive, to the behaviours of women and staff during their time in the centre. The discussion section of the paper focuses on two elements of these findings, that of nesting as " psychosocial safety" (p 235) and " Psychological safety and ' matrescence'" (Walsh, 2006 p 236). The author contextualises <https://assignbuster.com/nesting-and-matrescence-as-a-birthing-strategy/>



these findings within the current medical model, demonstrating a level of engagement with women on the part of midwives that goes beyond clinical actions to something more nurturing and much more intimate. The complexities of women's experiences of birth are continually referred to in the literature, and yet there is little apparent significance paid to these when the overarching concern of 'live mother and live baby' is trotted out as the final justification for any kind of maternity care that transgresses women's preferences or emotional responses. Choices in childbirth are in particular complex, and the kinds of decisions that women make about their birth location, experience and preferences are not only related to their individual preferences and knowledge but to the socially-acquired knowledge and attitudes they have developed, which are significantly affected by obstetric models and concerns over 'safety' (Magill-Cuerden, 2006). It is apparent from this article that understanding the psychosocial, emotional and even spiritual dimensions of the birth environment, including the relationship with maternity care providers, provides depth of insight into women's needs and into what can realistically be offered them under that all-encompassing, frequently-touted term 'support'. Women need to understand the factors that influence their decisions (Magill-Cuerden, 2006), but women and midwives also need to understand the ethical, emotional and relationship dimensions of their 'matrescence', the process of becoming a mother (Walsh, 2006).

The implications for practice here are significant, because, working in the medical model of care, midwives are often hampered in their ability to provide the psycho-emotional or spiritual aspects of care and nurturing

which are highlighted as so significant in this paper. Also, there may be midwives and maternity care assistants who do not have the requisite sensitivity, trust in women and themselves, and emotional intelligence to reach this level of practice. Walsh (2006) cites all-too-family “unhelpful behaviours” including “paternalism, being patronising” and “indifference and fear of intimacy” (p 238). Thus, it can be seen that for many midwives achieving what is described in this paper is not suitable. The anecdotal evidence from clinical midwifery practice is that, in the opinion of many, midwives who can achieve this state work in the community or in birth centres, and those who cannot opt for high risk, centralised maternity care areas in which they either can avoid this level of engagement with the client or are actively discouraged by organisational or ward culture from doing so.

Walsh (2006) makes the following recommendation:

“These findings lead me to believe that midwives should seek ways to rehabilitate ‘nurture’ and ‘love’, derivative of matrescence, as familiar childbirth language and as mainstream caring activities in childbirth.” (p 238).

However, attention would also need to be paid to the effects on midwives themselves, who may suffer from emotional backlash or even burnout, particularly in the current UK context. This would also have implications for the nature of pre-registration midwifery education in the UK, because it would have to become part of the process of becoming a midwife, and it is much harder to teach abstract aspects of ‘becoming’ than it is to run emergency drills and teach students how to critique research papers.

However, if such a paper can be used as evidence to change practice, then it would, overall, be a positive change.

## Conclusion

A critical evaluation of this qualitative paper has highlighted its strengths and weaknesses, in that the author has adhered to principles of qualitative research, has selected a question or area of enquiry which demands a qualitative approach, and has demonstrated an ability to use such research to reflect woman-oriented ways of knowing (Hicks, 1996). There are limitations to the study, one of which is that the author does not really explore its limitations in any great depth, but overall the quality of data analysis, exploration and discussion is such that the lack of detail about basic research principles is eclipsed. The author firmly locates the study within the current context, but could go further in exploring the impact on midwives if such principles do succeed in changing practice. While Cluett and Bluff (2006) state “ practice based on traditional knowledge is no longer acceptable” (p 276, Walsh (2006) has taken ‘ traditional knowledge’ and ‘ tested’ it through a study of one particular birth setting, and provided a reasonable level of evidence (in terms of midwifery care at least) for the benefits of certain underlying principles of what has been discarded by the medical profession as the unimportant emotional side of maternity care.

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