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**MIDWIVES AND MOTHERS:
REPRODUCTIVE IDENTITIES AND
EXPERIENCES**

By

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ABSTRACT

This thesis explores gender identity in relation to reproduction, midwifery and motherhood from the perspectives of midwives and mothers. Using auto/biography this research emerged from my own embodied experiences of reproduction, childbirth and midwifery. It questions how experiences of reproduction might shape the identity of the midwife and the relationships between midwives and mothers. This research focuses on three specific aims; first, to contribute to the theoretical and sociological understanding of gender identity; second, to explore midwives' personal experiences of pregnancy and birth, and how their embodied experiences influence practice; and third, to contribute to the understanding of the 'meaning of motherhood', from the experience of midwives and mothers.

Following in-depth interviews with fourteen midwives and thirteen mothers, the research findings show that gender expectations of midwives as female carers are bound by socially constructed expectations of the identity of the midwife as a carer, in which the role of emotion is a key theme. This thesis illustrates how the analysis of gender identity shows the interconnectivity between midwifery, reproduction and motherhood, and emotion. It contributes to the understanding of the relationship between emotion, midwives embodied experiences of reproduction, childbirth and motherhood, and the issue of professional identity. The findings highlight the significance of emotion in mediating the relationship between midwives' experiences and their practice, especially in the context of midwives' identity. This research provides an insight into the relational aspects of emotion work within reproduction and childbirth, and reveals that emotion work is not limited to midwives, but their actions or inactions can create emotion work for mothers.

Recommendations for policy and practice emphasise the significance of community based midwifery services, a review of hospital based postnatal care; and highlight the need for the support of midwives returning to work following maternity leave. Future research recommendations focus on the development of auto/biography as a research approach and the exploration of emotion in midwifery research; issues of midwifery care; embodied experiences and the identity of the midwife.

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CONTENTS

ABSTRACT	i
ACKNOWLEDGEMENTS	ii
CONTENTS	iii
LIST OF TABLES	vi
INTRODUCTION	1
AIMS AND RESEARCH QUESTIONS	2
STRUCTURE AND PRESENTATION OF CHAPTERS	4
CHAPTER 1: GENDERED IDENTITY, REPRODUCTION AND MIDWIFERY	8
INTRODUCTION	8
IDENTITY AND ITS RELATIONSHIP WITH GENDER	9
BIOLOGICAL SEX, GENDER AND IDENTITY	14
EMBODIED GENDER IDENTITY	19
Pregnancy and Childbirth	22
GENDER AND MIDWIFERY	26
Gender and the identity of the midwife	26
Gender and the provision of care	33
CONCLUSION	37
CHAPTER 2: THE SITUATED RESEARCHER	40
INTRODUCTION	40
INTRODUCING THE RESEARCHER	41
DEVELOPMENT OF A THEORETICAL FRAMEWORK	45
Women’s experiences	48
REFLEXIVITY	51
THE CONTRIBUTION OF AUTO/BIOGRAPHY	59
PHENOMENOLOGY	61
FEMINIST EPISTEMOLOGY AND GADAMERIAN PHILOSOPHY	62
FEMINIST CRITIQUES OF GADAMER	65
CONCLUSION	67

CHAPTER 3: DOING RESEARCH WITH WOMEN	69
INTRODUCTION	69
ETHICAL CONSIDERATIONS	70
Working as a lone researcher	72
SELECTING STUDY GROUPS	74
Advertising and recruitment	76
THE USE OF A REFLECTIVE DIARY	77
Personal reflections	78
RECRUITMENT OF MOTHERS	80
CHARACTERISTICS OF THE STUDY GROUP	83
USE OF IN-DEPTH INTERVIEWS	84
Conduct of interview	85
Developing and revisiting preunderstandings	89
Recording and transcribing	89
ANALYSIS OF INTERVIEW DATA	90
Hearing and writing the reproductive biography	92
Hermeneutic interpretation- developing meaning	92
Construction and presentation	93
CONCLUSION	94
CHAPTER 4: CONSTRUCTING A MIDWIFERY IDENTITY	96
INTRODUCTION	96
THE IDENTITY AND CULTURE OF MIDWIFERY	97
THE RELATIONSHIP BETWEEN NURSING AND MIDWIFERY	99
CARING ASSOCIATED WITH PERSONAL EXPERIENCE	104
MIDWIFERY, MOTHERHOOD AND THE CARE OF BABIES	108
LEARNING TO BECOME	110
BEING A MIDWIFE	113
CONCLUSION	116
CHAPTER 5: REPRODUCTIVE IDENTITIES	118
INTRODUCTION	118
THE PREGNANT MIDWIFE: A TRANSFORMING IDENTITY	119
Physical demands of midwifery work	122
The emotional context of midwifery work	124

RECOMMENDATIONS FOR FUTURE RESEARCH	212
FINAL THOUGHTS	214
REFERENCES	216
APPENDICES.....	238
APPENDIX 1: Information Form - Midwives	238
APPENDIX 2: Information Form - Mothers	240
APPENDIX 3: Consent.....	242
APPENDIX 4: Opt - in form	243
APPENDIX 5: Biographies Of Midwives	244
APPENDIX 6: Biographies Of Mothers.....	247
LIST OF TABLES	
Table 1: Inclusion And Exclusion Criteria For Study Group Of Mothers Within The Postnatal Period.....	76

INTRODUCTION

In 1999, having spent eleven years as a midwife in clinical practice, I moved into higher education where I had the opportunity to share my knowledge and expertise in the education and support of student midwives. During my first year as a midwife teacher, I became increasingly aware of how the culture of midwifery education had changed since I was a student. I was particularly surprised to find that many of the students were mothers; based on their experiences they spoke with such clarity and conviction about the role of the midwife and the philosophy of midwifery care, that it made me question the impact of such personal knowledge and understanding, on both the practice of midwifery and the identity of the midwife. As a result I examined my own experiences of midwifery education and training as a student; I had no personal insight into midwifery or motherhood to draw upon. My interest in midwifery was inspired by professional observations and experiences of midwifery as a student nurse. Therefore I questioned how the experiences of reproduction could influence the identities of midwives in terms of how they viewed themselves; had my perspectives of midwifery and my understanding of who I was changed since the birth of my son? Would I have been a 'better' midwife if I had had my baby before I become a midwife, or, as a result of my experiences, would I have actually stayed in nursing?

Having practised midwifery for eight years before becoming a mother in 1996, I reflected on the wealth of professional experience I had gained and started to think about how pregnancy and childbirth could shape midwives' identities as professional women; also I thought of how being a professional could affect the experience of childbirth and motherhood. During pregnancy and childbirth, pregnant women so often ask midwives: 'Have you got children?' Reflecting on this question made me think of how mothers viewed midwives in relation to reproduction. Whilst the professional role of being 'with woman' may be influenced by many factors, the issues around midwifery and motherhood had not been examined in this context. I questioned whether the gender of the midwife as a woman was significant to mothers' expectations of midwives because midwives work primarily in a female environment where the focus is based on the process of reproduction. Furthermore, the gender relations between women around birth described as the 'emotionally connected and biographically grounded relationship' (Wilkins 2000:34), became a significant area of interest to me.

The possible contribution of gender in this context raises questions in relation to the nature of relationships between midwives and mothers around reproduction and motherhood. Firstly, if the midwife's ability to form relationships is shaped by her embodied experiences of reproduction and motherhood, then it could be argued that negative as well as positive reproductive experiences may influence the relationship between them in some way. Furthermore I questioned whether the midwife's reflection on her embodied experiences could be used in midwifery encounters with mothers either to empower mothers or possibly act as a barrier to the development of relationships. Mander (1996:188) suggests that midwives who have personal experience of childbirth may draw inappropriate conclusions about mothers as a result of their own experiences. Secondly, since historical accounts of midwifery education and practice place a great importance on the midwives' own experience of childbirth (Donnison 1988), and in many cultures it appears to be a pre-requisite to practice (Jordon 1978), I questioned whether mothers view midwives as the embodiment of childbirth experience. References to embodied experiences of childbirth within practice or reliance upon it as a basis for practice could shape the identity of the midwife and contribute to the care provided. Whilst it is argued that the relationship between the midwife and the mother should be based on mutual trust and respect (Cronk 2000), the extent of the contribution of the embodied reproductive experiences of midwives is uncertain.

AIMS AND RESEARCH QUESTIONS

This thesis explores gender identity in relation to the midwife and midwifery work and it has three aims. The first aim is to contribute to the theoretical and sociological understanding of gender identity in relation to reproduction, midwifery and motherhood. Within this thesis I present an exploration of the possible meanings and significance of the relationship between identity and gender in terms of understanding how gender operates within midwifery. The significance of gender identity within midwifery is considered in relation to essentialist claims that caring occupations are established on the basis of the relationship between caring work and femininity. This thesis presents a feminist analysis of the issues of gender identity in relation to midwifery work and motherhood.

The second aim is to explore midwives' personal experiences of pregnancy and birth and how their embodied experiences influence practice. The extent and rationale to which

midwives may disclose their personal accounts of pregnancy and birth within their encounters with mothers are significant issues. I was also interested in exploring whether mothers perceive this personal disclosure of information as useful and whether the midwife is perceived differently as a result. In the interviews with midwives, I explore their personal experiences of reproduction and birth and their professional relationships with mothers. The interviews with mothers focus on their accounts of pregnancy and birth and their relationships with midwives.

The third aim of the research is to contribute to the understanding of the 'meaning of motherhood' from the experience and perspectives of midwives and mothers. This is explored in relation to how motherhood is perceived and experienced by midwives. Therefore, the embodied nature of gender within midwifery is considered in relation to essentialist claims that caring occupations are established on the basis of the relationship between caring work and femininity and is closely aligned to the issue of mothering.

In order to develop some understanding of the identity of midwives, the perceptions of mothers are considered to be important. Within this thesis I explore the working elements of gender identity, with regards to the relationships and experiences of reproduction, evidenced by the accounts of both midwives and mothers. For this reason, I specifically focused my research on the relationship among women. My intention was to draw attention to the experiences of midwives and mothers, not to make comparisons, as this would privilege some experiences above others. I illustrate the difference and similarities between mothers and midwives as women to illuminate and validate their embodied experiences.

To theorise further, I broaden the discussion to include issues around the male midwife. Whilst there is a small number of male midwives within the profession, this thesis concentrates on the gendered nature of midwifery insofar as it is perceived to be an example of 'women's work.'

Three specific research questions were developed from the initial exploration of the aims outlined above. These are;

1. How is the identity of the midwife constructed?
2. Do the reproductive experiences/expectations of midwives influence their practice and the way they care for mothers?

3. How do midwives and mothers view motherhood and mothering in the context of midwifery care and how maternal identities are constituted in this encounter?

These questions draw specifically from my embodied experiences of reproduction, midwifery and motherhood and act as a basis for the exploration of the relationship between gender and identity in relation to these issues. Thus this thesis presents a reasoned analysis of the relationship between gender and identity with regards to the relationships and experiences of reproduction from the analysis of the accounts of fourteen midwives and thirteen mothers.

STRUCTURE AND PRESENTATION OF CHAPTERS.

The structure and presentation of chapters within this thesis have been specifically organized to reflect the uniqueness of the research and its focus. Following this introduction, Chapter 1: *Gendered Identity, Reproduction and Midwifery*, is a discussion of the contribution of the main body of literature that centres on the debates about the definition of identity and gender. Within this chapter I examine gender identity in relation to the essentialist features of the category woman and question whether it is possible to have such a category which is non-essentialist. This is examined in relation to the issue of difference among women rather than oppression by men within a patriarchal culture, and examined in relation to women's experiences and sense of self. The contribution of the debates around the 'sex/gender binary' and embodiment are considered. The implications of binary positioning and the essentialising of feminine characteristics are examined in relation to gendered identities within midwifery. This discussion is positioned to reflect the nature of midwifery work; I examine midwifery and motherhood as 'women's work,' by examining the embodied nature of midwifery care in which caring is considered a natural aspect of femininity. The relationship between knowledge, expertise and embodied identities in relation to the midwife and midwifery work is central to this discussion.

Chapter 2: *The Situated Researcher* is the first of two methodological chapters. In the first one I consider the theoretical justification for the application of auto/biography within a feminist context and start by introducing the feminist theoretical framework applied. Since the focus in this research is placed on the experiences of midwives and mothers, I draw on aspects of Feminist Standpoint Theory (FST) to support my research. This theory

is grounded in the relationship between gender and knowledge production, where the exploration of women's experiences is central to understanding women's lives. I also present a critique of its limitations in relation to its reluctance to consider difference in relation to the fact that whilst women share something as women, not all women will share the same experiences.

For this reason I begin by emphasising the auto/biographical nature of the study drawing on my own biographical accounts of reproduction, childbirth and motherhood in order to position myself as the situated researcher in relation to the focus of my research. I discuss positionality and reflexivity to locate myself within the discussion and discuss the contribution of auto/biography to this thesis. I state my position in relation to the inception and planning of the research but justify my absence from the data chapters as a strategic decision to give midwives and mothers the opportunity to be forefronted. I reflect again on my position as a situated researcher in the concluding chapter to reflect on the use of my biography within the research. The appropriateness and relevance of hermeneutic phenomenology within the wider feminist context is considered as a means of exploring women's experiences. It is important to consider the contribution of phenomenology because it provides a means of exploring the lived experiences of women.

In the second methodological chapter, Chapter 3: Doing Research With Women, I discuss the practical issues of doing the research in terms of detailing the recruitment of two study groups comprising fourteen midwives and thirteen mothers. Biographical accounts of the two study groups are presented in Appendix 5 and 6 to support the discussion of the structure and characteristics of the study groups. Methodological issues including ethics and the conduct of in-depth interviews are supported by Appendices 1-4, and by my personal reflections of the process as a situated researcher. The thematic analysis method employed was inspired by the work of Fleming, Gaidys and Robb (2003) and Clarke (1999). This approach embraces the philosophical nature of Gadamerian Hermeneutics (Gadamer 2003), which centres on the conditions necessary to make understanding and interpreting experience possible. Gadamer suggests that the understanding of both the researcher and respondent come together to achieve a shared insight or 'fusion of horizons.' For this to take place, the position and experience of the

researcher is significant. This philosophical positioning supports my use of auto/biography in this research and my position as a situated researcher.

Four detailed data chapters' follow and these illustrate the richness and depth of the data generated from the in-depth interviews. The structure and presentation of the four data chapters not only reflect the primary focus on midwives but also the relationship between midwives and mothers; Chapters 4 and 5 focus predominantly on the midwives, whilst Chapters 6 and 7 discuss the interviews with midwives and mothers. This is a strategy used to illustrate the development and construction of identities of midwives and also demonstrates how mothers' experiences' shape and influence the midwives' identity construction.

In Chapter 4: *Constructing a Midwifery Identity*, I explore how the identity of a midwife is socially and professionally constructed in relation to stereotypical representations of the female caring role. Centred on instinctive and personal feelings of wanting to care, I discuss the importance of midwives' embodied knowledge of motherhood and nursing in relation to professional socialisation. Tension between the use of professional or formal knowledge and experiential knowledge of reproduction and motherhood, is examined in relation to the experiences of midwives who are mothers and non-mothers. As a result, knowledge development within professional socialisation is an important aspect of the identity of the midwife. This chapter concludes with a discussion of identity in relation to the transition to professional practice.

In Chapter 5: *Reproductive Identities*, I develop the discussion further by focusing on the relevance of reproductive experiences and the use of embodied experiences for the construction of midwives' identities. I examine the nature of their identities in relation to professional and embodied experiences of experience of childbirth and motherhood and consider the conflicts that occur in the management of co-existing identities.

Following this I build upon the discussion from the two earlier data chapters to discuss the identity of the 'Good Midwife' and the identities of 'Others' as described in the accounts of midwives and mothers. In Chapter 6: *The 'Good Midwife' and 'Other' identities*, the concept of the 'Good Midwife' is considered in relation to the provision of care rather than individual competency. 'Othering' is used to determine the difference between midwives who were considered to be 'good midwives' and those who were not.

The maternal identity of the midwife is a significant aspect of this discussion and reflects the way in which midwives support women within midwifery care.

In the final data Chapter: The Midwife As Carer: Maintaining A Woman-Centred Identity (Chapter 7), I consider the extent to which the midwife can assume the identity of carer. In this chapter using mothers' accounts I explore the identity of the midwife as carer, focusing on the mothers' accounts of experiences that challenge this identity construction and those which confirm it. To underpin this discussion, I consider the extent to which the care described by the study group of mothers reflect the contemporary philosophy of woman-centred care.

In the concluding chapter, Discussion and Final Reflections, I revisit the aims of the research and explore the main findings of the research. The exploration of the issue of gender identity in relation to the midwife and midwifery work extends this focus to encompass the relationship between gender identity and emotion. With reference to current theoretical work, I consider the original contribution made by the thesis to the sociology of emotion. Within this chapter the significance of emotion within the relationship between midwives and mothers is considered in terms of how this can create different sources of emotion work for midwives and mothers, and, how midwives use their embodied knowledge of pregnancy and birth in different ways within their practice. The emphasis on maternal support within midwifery care is also discussed as a feature of the relationship between midwifery and motherhood, represented by the conceptualisation of the identity of the 'Good Midwife'.

I also return as the situated researcher to reflect on my experiences of using an auto/biographical approach and consider the relationship between this approach and emotion. My discussion centres on how undertaking this research has enabled me to reflect on my experiences and the way in which my experiences have influenced my identity as a midwife; conversely I consider how being a midwife shaped my experience of childbirth and motherhood and formed my identity as a mother. Within this discussion I therefore consider some of the challenges and also future opportunities for the use of auto/biography in midwifery research. Limitations of the research as also discussed and recommendations for practice, policy and future research are presented.

CHAPTER 1

GENDERED IDENTITY, REPRODUCTION AND MIDWIFERY

INTRODUCTION

This chapter considers the tensions between the theoretical contributions of biological essentialism and social constructionist theories of gendered identity. To achieve this I firstly consider how the interaction between the theoretical positioning of biological determinism, socialisation and social construction relate to the identity of both midwife and mother as women and, secondly, explore the wider application of this theorising to the sociological interpretation of gendered identity in relation to midwifery work and motherhood. Within this chapter I demonstrate that it is possible to have a category woman that is not essentialist, by focusing on the context of experience, and the similarities and differences between and among women in relation to their experiences, rather than on their assumed shared oppression.

The chapter is divided into two parts. In the first I examine the relationship between gender and identity, the meanings that can be drawn from this relationship and how the concept of gender identity can be understood in relation to women's experiences and sense of self. Gender identity is examined in relation to the essentialist features of the category woman; the implication of the debates around 'sex/gender binary,' are considered, followed by a discussion of the contribution of embodiment. In the second, I focus on the implications of binary positioning and the essentialising of feminine characteristics in relation to gendered identities within midwifery. I discuss the extent to which essentialist claims reflect the nature of midwifery work and by examining the embodied nature of midwifery care, I examine midwifery and motherhood as 'women's work,' in which caring is considered a natural aspect of femininity. The relationship between knowledge, expertise and embodied identities in relation to the midwife and midwifery work is central to this discussion.

IDENTITY AND ITS RELATIONSHIP WITH GENDER

The understanding that gender identity is predominantly constructed on 'an apparently paradoxical combination of sameness and difference' (Lawler 2008:2) is significant. By

adopting Lawler's definition as the basis of this research, I accept her position that gender identity in this context is a process of identification. This is a reflexive process in which women develop their identities in terms of understanding who they are rather than who they are not, based on a process of sameness and difference. I also suggest that in addition to identification, the opposing concept of dis-identification is relevant in relation to mutually exclusive categories; that is women can identify that they are not men. In this context identities are constructed in relation to difference and, 'all rely on *not* being something else' (Lawler 2008:3 emphasis in original text). The concept of dis-identification is not used here as a means of marginalizing women who are different, neither is it used to suggest a process of stereotyping, although both aspects have been suggested in the literature in relation to midwives and mothers (Bowler 1993).

I argue here that identification is a process of sameness and difference and is integral to the development of gender identity. Goffman (1990) considered identity in relation to theatre, in which individuals play different roles in response to different audiences. As part of this performance he describes the personal front that acts as a backdrop for the performance. He describes this as part of the dramaturgical performance that is consistent; this constitutes a way that clarifies the role of the actor. In this way I argue that the personal front is fixed. For Goffman the front stage separates the setting of the performance from the personal front, thus I argue that Goffman's actor requires some consistent understanding of self in order to facilitate a performance; in the context of my research this is an understanding of gender as an intrinsic consistent self. For midwives, I argue that gender identity is a stable identity, which is more than a role in the sense of being socially scripted because midwives and mothers have strong investment in motherhood. What I mean here is that Goffman's theatrical frame is useful to understand the management of emotion within midwifery (Hunter 2004a; 2004b; 2005; 2006; Deery 2009). I discuss emotion work in more detail later in this chapter.

Lawler's definition is also useful in terms of the positioning of gender identity in relation to the experiences of women around reproduction, childbirth and motherhood. This definition of identity acknowledges the relationship between women as a basis from which to explore how difference and diversity, in relation to their experiences of reproduction, can occur. By accepting this position, I adopt a non-essentialist position in which I accept that not all women will desire motherhood or become biological or social

mothers; whilst pregnancy, childbirth and motherhood will be variously experienced by others. Women identify with other women on the basis of their gender but they may not share all the aspects or features of all women; differences in social class, ethnicity, sexuality and disability may affect women's lives and their perceptions of what a woman is. In this way, women identify common aspects which are shared and dis-identify with aspects which are different between them. The process of identification and dis-identification promotes the uniqueness of individual experience. For example, Earle (2000:238), in the study of the maintenance of self-identity through pregnancy, argues: 'The construction of self-identity during pregnancy seems to require not only the maintenance of a similarity to others but, also, a sense of uniqueness.' In this context, identity is constructed vis á vis others where a process of finding similarities and differences validates individual experiences and contributes to the construction of self-identity.

By adopting this definition I privilege women's experiences by accepting that women may not experience the world in exactly the same way. Whilst I recognize that other social divisions such as those based on ethnicity, class, sexuality and religion are important dimensions of identity, I argue here that gender is a primary dimension of identity that intersects with every aspect of an individual's personal and social identity. Järviluoma, Moisala and Vilkkö (2003:1) state that:

Gender is an important criterion in identifying ourselves and is central to the way we perceive and structure the world and events in which we participate. It influences all aspects of our being, of our relationships and of the society and culture around us.

If we accept that gender is a key dimension of identity, it is possible to consider how women negotiate their own concept of self-identity in relation to what it is to be a woman in different situations; for example previous work by Wadsworth and Green (2003) describe a loss of gendered identity felt by women when experiencing the menopause. Although other aspects of identity may be important at different times, gender is a constant and is especially important in relation to women's perspectives on reproduction. However, it is not my intention to suggest that gender identity is constructed in isolation from other aspects of identity. Spelman (1988) for example, considers how the interplay between race, class and gender can have an impact on women's experiences of the world. Her use of the word 'inessential woman' refers to the bias within feminist work where the experiences of white middle-class women are

privileged above those of women of colour or those from different ethnic groups. This may be particularly significant in relation to the reproductive experiences of marginalized groups of women; for example women from minority ethnic groups (Bowes and Domokos 2003; Jayaweera, D'Souza and Garcia 2005), low socio-economic status (McIntosh 1988; Bailey, Pain and Aarvold 2004) and lesbians (Wilton and Kaufmann 2001; Wojnar 2007).

However, it is important to consider whether Lawler's definition is a valid definition of identity in relation to the focus of my research and this thesis. In order to accept that it is, the suggestion that identity is negotiated in relation to a pre-given or core identity must be considered; in this case I suggest that gender acts to an extent as a fixed aspect of identity. Whilst this may be viewed as essentialist, I argue that gender is both central to the construction of identity and offers continuity. In drawing on the work of Mead (1934) in relation to 'I' which is internal and relates to the self, and the social 'me' that relates to the external and is influenced by the perspectives of others, it is suggested that the presence of the 'I' does provide a continuous sense of self; I suggest that a woman's sense of self is negotiated in relation to her gender which is known. The self as theorised in this context is reflexive. Woodward (2002:9) writes:

Thus 'I' understand myself through imagining how I am understood by others – as 'me.' Consciousness alone is insufficient; one has to be conscious of something. 'I' only exists in relation to the 'me' upon whom I reflect. Mead's interactive, reflective self is part of the society which provides the meaning, based on experience, which is the substance of reflection.

In this context it can be argued that identity-to some extent-is free from social determinism in which women have, 'both an inter- and intra-subjective model of the self' (Haynes 2006:401), but is always in negotiation. However, although Mead's work suggests a distinction between 'I' and 'me' which suggests a sense of autonomy and agency in relation to identity, the relationship between the 'I' and the 'me' in this context does not reflect the conflict which exists between self and society which challenges the stability of the relationship between the 'I' and the 'me'. The issue of conformity, in which societal expectations that each woman will become a mother, reflects the social construction of motherhood as a 'natural' and biological role for women, central to the ways in which they are defined by others and to their perceptions of themselves (Phoenix and Woollett 1991). The extent to which gender identity is autonomous and free from social influence is therefore questioned. This supports Butler's (1990) position in which she states that the

continuity of self-identity is not based on a pre-existing 'I' but on social regulatory practices and is socially constructed.

To address this point further it is important to consider that Mead proposed the existence of the 'generalised other' in which it represents 'the organised community to which an individual belongs and against which she is poised and defined' (Jenkins 1996:42). This suggests that each person has a 'generalised other', which enables the interaction between the 'I' and the 'me' to take place. The self in this context is a social or empirical self, which is reflective and 'conscious of the positioning of that self within the broad framework of social relations' (Woodward 2002:9). On this basis it is suggested that women may reflect on their identity as women in relation to their perceptions of what a woman is or should become, and this may be influenced by the combination of socialisation, social construction and the influence of biology.

Identity in the context of this discussion therefore represents a process, which is continually negotiated both in terms of the social and inner self. It is also a process that represents the existence of identification and the presence of multiple identities, which highlight the social interaction that takes place within the social construction of identity. Since identities are socially constructed, situated and multiple, a woman who is mother, midwife and wife is constantly negotiating and renegotiating her identity in relation to specific situations and through this process may find that managing her multiple identities creates contradictions. Lawler (2008:3) clarifies this point:

No one has only one identity, in the sense that everyone must consciously or not identify with more than one group, one identity. This is about more than combining multiple identities in an 'additive' way. As several feminist writers have pointed out, identities impact on each other.

These contradictions I argue here can be analysed in relation to the impact of the construction of self-identity vis à vis interaction with others. As Jenkins (1996:29-30) writes:

...an individual's reflexive sense of her or his own particular identity, constituted vis à vis others in terms of similarity and difference, without which we would not know who we are and hence would not be able to act.

Firstly, contradictions can occur when maintaining balance between old and new identities, where the construction of new identities such as in motherhood may challenge the established identity of the professional. This is especially significant in the experiences

of professional women who find being pregnant at work a process of balance and negotiation between their reproductive labour and paid employment (Forester 2000; Raddon 2002; Gatrell 2005; Haynes 2008). Women who combine motherhood and employment, especially full time working, are criticised for not caring for their children, whilst those who work part-time are considered to lack work commitment. Gatrell and Cooper (2008: 81) summarise the difficulties for mothers in relation to employment:

Thus, a professional and/or managerially employed mother who works full-time may find herself constructed simultaneously as a 'nominal' mother, who is failing to perform her maternal role appropriately, and also as an uncommitted, unambitious employee (Moorhead, 2004, p.10) – when, in fact, she may be deeply committed both to her children *and* to her paid work (Gatrell, 2005).

Secondly, contradictions also occur when women who do not assume the socially constructed identity of mother become constructed as 'Other'. Whilst 'Othering' is considered as a negative process in the oppression of women (de Beauvoir 1953), I consider here that 'Othering' is a relational process, which occurs as part of identity construction. Weis (1995:18) defines 'Othering' as; 'that process which serves to mark and name those thought to be different from oneself.' Canales (2000:20) concurs and suggests that; 'Othering is a complex interrelational process that shifts depending on how identities are constructed and interpreted.' Canales also defines 'Othering' as an exclusionary process, in which individuals can be marginalised, alienated and stereotyped. She adds; 'Persons from subordinate groups may also experience Self-Othering, internalizing the Exclusionary Othering perpetuated against them' (Canales 2000:20). In this context the 'Other' is stigmatized. This is especially significant for women who do not become mothers as a result of infertility or reproductive loss, and those who refuse biological motherhood (Letherby 1994; Gillespie 2003), who are considered to have ambivalent identities. These experiences can lead to feelings of being incomplete (Letherby and Williams 1999). Moreover, when motherhood is refused, women are perceived 'as unfortunate or psychologically flawed, selfish, and deviant, in the unnatural unhealthy and unfeminine lifestyle that they are perceived to embrace' (Gillespie 2003: 124).

The discussion of identity in relation to women's lived experiences may therefore encompass some reference to reproduction whether as a specific identity of mother or in combination with other aspects such as ethnicity, social class, and occupational identity. Whilst I have alluded to the influence of the social construction of gender identity, in the

context of reproduction, biological difference between men and women gives rise to debates around women's desire and ability to have children. Reproduction and motherhood are claimed therefore to be an essential part of the 'natural' identity of women; expressed as a dominant discourse of fulfilling the essentialist ideas of biological and maternal instincts (Woodward, 1997). To develop this discussion further, I frame the discussion of essentialism around the issue of biological essentialism. Biological essentialists claim that gender differences are not differences in socially constructed meanings of gender but reflect a biologically based difference that is consistent across cultures and gives rise to the social positioning of women as mothers. Grosz (1994:84-85) refers to the term biologism and writes:

Biologism is a particular form of essentialism in which women's essence is defined in terms of biological capacity...Insofar as biology is assumed to constitute unalterable bedrock of identity, the attribution of biologicistic characteristics amounts to a permanent form of social containment for women.

If accepting the claim that women's identity is based specifically on biological difference, (and accounts for their desire and ability to have children), then it is argued that it limits the social possibilities of women and alienates those who do not fall into the category of woman defined in this way. It also assumes that all women will possess the ability to conceive and birth successfully and possess the necessary characteristics to mother. Davis and Walker (2008:3) write:

Essentialism assumes that all women are the same (as they share a common essence), locking women into an essential characters and so failing to appreciate the diversity of women's experiences and ways of being. Biologism locates this essence in a woman's biology, thus failing to recognize the way that we are shaped by our social and cultural context. It is complicit with masculinist assumptions as it firmly establishes fault within women's unalterable biology.

However the relationship between biological sex and gender identity is more problematic. To develop this discussion I consider the contribution of the 'sex/gender binary' debate.

BIOLOGICAL SEX, GENDER AND IDENTITY

Gender and identity debates in relation to women and reproduction centre on the issue of biological sex. Oakley (1979) defined 'sex' in relation to biological differences between women and men; 'gender' is used to define 'the socially and culturally ascribed characteristics attributed to women and men' (Earle and Letherby 2003:3). In this context it can be assumed that sex is deemed to be a natural biological state determined by

biological differences; whereas gender is the social expression of these differences. However the distinction termed 'sex/gender binary' created by considering each of these opposing concepts separately has been variously debated within the literature. Whilst successive social and feminist theorists (Friedan 1963; Oakley 1981a; Spelman 1988; Grosz 1994), have questioned the 'sex/gender binary' on several levels, three assumptions are worth further consideration here. The first assumption is that sex determines difference between men and women. To understand human behaviour, a great deal of emphasis is placed on the assumption that differences between males and females are believed to be as a result of sex differences. In this context male and female are considered as binary opposites, creating a 'natural' distinction between the two. Biological differences have been used to explain behavioural differences between men and women; for example the development of the sex-role theory contributed to the development of sex roles in which women were deemed to have a nurturing instinct and men more aggressive and able to provide for their families. Stone (2007:141) claims:

..the word 'woman' is ambiguous between sex and gender....the word predates the sex/gender distinction, and so it embodies the pre-feminist view that women's status and psychology are neither social nor changeable but fixed by biology.

It is argued that sex differences in this context can be used as a means of promoting the 'inferiority of women' (Oakley 2005:20) in which women are considered as weak and vulnerable, contributing to a system of gender oppression.

Although it is important to acknowledge the anatomical differences between men and women in relation to reproduction, to assume that these differences are responsible for differences and similarities in relation to identity neglects the influence of socialization. Whilst the work of Mead (1962) considers how gender roles change across and within societies, Howard and Hollander (1997) suggest that gender is a process of learned behaviour in which men or women are influenced by culturally acceptable activity. Butler (1990) also informs us that gender practices are instigated at birth and continue throughout childhood. She suggests that at birth the announcement of the sex of the baby determines a whole host of social practices starting with the use of pink and blue clothing and accessories that promote the identity of the child in relation to its sex. In this context she considers that sex is as much socially constructed as gender. Moreover as Oakley (2005:19) notes that 'biology is not a given, a cultural constant,' which suggests that the biological body is not considered in the same way across cultures. She says 'One

reason why nature versus nurture debate is outmoded, in other words, is because nurture affects nature' (Oakley 2005:19).

The second assumption to be addressed here is that sex as a method of biological classification is considered a more stable and static contribution to identity than gender. Drawing on the work of Stanley (1984), Woodward (2002:107) considers the argument of separating the two concepts of sex and gender as:

...being one between *biological essentialism*, which prioritises biological, embodied sex as the determinant of femininity or of masculinity, and *social constructionism*, which focuses on gender as a social cultural category.

The hierarchical nature of this binary distinction has presumed that sex should determine gender. This assumption can be critiqued on the grounds that whilst biological essentialism dictates that there can only be bipolar sex - man and woman- in a normative context, the relationship between sex and identity has been contested on the grounds that behaviour deemed to reflect individual identity cannot be explained by the presence or absence of specific genitalia alone; this is especially relevant to studies of transgender, transsexual and intersexed individuals in which the assumption that gender identity corresponds to biological sex is incongruent. Separating these concepts enabled Stoller (1968) to explain transsexuality where sex and gender did not align with each other. The relationship between sex and gender was also challenged by Diamond (2000:46-47) who draws on the work of Kessler and McKenna (1978) to suggest:

...transsexuals seek to reconstruct their sex to coincide with their psychological gender. Doesn't this imply that it is their gender which is primary and their sex secondary? Analysis of the thinking of transsexuals is simultaneously used as a foil to bolster the Kessler and McKenna argument that the study of gender benefits from insightful and detailed analysis of the thinking of individuals as they make significant gender related decisions... to rectify the dichotomy, the transsexual is seen as not wanting to change gender but change genitals and body. It thus appears that sex is variable and gender invariant; a reversal from the way the two had come to be considered. But the transsexual, according to our authors, then sets about *learning* or perfecting how to be the man or woman of mind's desire. In so doing, the transsexual proves to Kessler and McKenna that gender is a construction that doesn't necessarily follow from anatomy.

Biological sex as a category is therefore neither universal nor straightforward as an explanation of identity and cannot be considered as the sole basis of difference. In this context sex does not determine gender but gender as a socially constructed concept determines the individual identity. The use of the word gender introduces the possibility that as a socially and culturally constructed concept, an individual may define their own

identity in relation to differences between them and others. In this way, whilst sex is determined as biological difference, identity develops as a result of social and cultural experiences.

So far I have considered some of the key features of identity and considered the key contribution of the debates around the notion of biological sex and the sex/gender binary. However, in developing this discussion further, it is important to consider the feminist position regarding the use of the terms sex and gender in relation to women's position and experiences within society.

The feminist movement of the 1970s adopted the word gender to oppose biological deterministic views that 'biology is destiny.' In this context the social was privileged over the biological. Young (2002:412) writes:

At this theoretical moment challenging the conviction that 'biology is destiny' was an important feminist project. In order to argue for opening wider opportunities for women, we needed ways to conceptualize capacities and dispositions of members of both sexes that distanced behaviour, temperament, and achievement from biological or natural explanations. A distinction between sex and gender served this purpose. Feminists could affirm that of course men and women are 'different' in physique and reproductive function, while denying that these differences have any relevance for the opportunities members of the sexes should have or the activities that they should engage in. Such gender rules and expectations are socially constituted and socially changeable. Much of this early second wave feminist theorizing invoked an ideal of equality for women that envisioned an end to gender.

Second-wave feminist literature adopting different feminist positions (de Beauvoir 1953; Friedan 1963; Firestone 1970 and Greer 1970), considered that motherhood was a fundamental cause of the oppression of women and of social and political inequality. However by choosing to use the word gender rather than sex, biological determinism was replaced with social determinism, where difference was considered to contribute to the subordination of women through motherhood. Feminists (Risman 2001; Lorber, 2005) disputed the fact that gender was derived from sex although accepted that gender and sex were related. Smith (2009:76) presents an additional argument, which accepts the presence of biologism within the debate and writes:

It [gender] entered feminist currency to suppress reference to biology as determinative of women's inferiority. Dropping sex and adopting *gender* buried biology. Although legitimate as a political move, it has left us with no way of recognizing just how biology enters into relations among women, men, and children. I think of my bodily experience, particularly as a mother, and I am powerfully aware of how biological fundamentals entered into that experience—not

just in sex and childbirth but also in the profoundly physical pleasure of suckling a baby. Such experiences mark the intervention, or rather the ongoing presence, of human species' being in the doing of gender.

Smith not only considers the importance of embodiment here, but also the function of the body in relation to reproduction and mothering within the wider context of women's identity. Nicholson (1995:40) suggests that:

... 'gender' at that time was generally not seen as a replacement for 'sex', but was viewed, rather as a means to undermine the encompassing pretensions of sex.... Thus 'gender' was introduced as a concept to supplement 'sex', not to replace it.

Although criticized for being essentialist, theories of feminine gender identities developed by Gilligan (1982), Hartsock (1983), Chodorow (1999), and others, express that motherhood is an important identity for women. However their theories have been criticized for not considering the contribution of differences between women such as ethnicity and class to the construction of identity. In the examination of gender identity around reproduction and mothering, therefore, the presence or absence of anatomical features and functions are central to conception, pregnancy and birth and biological motherhood but not essential to non-biological mothering. However if we accept that some aspects of biology are important as a representation of women's gender identity, rather than claiming that biology is the basis of women's identity in terms of determining positioning, behaviour and value system the implications of any reproductive disruption may have ramifications for women's sense of self-identity. In this context the role played by biology must be acknowledged within women's experiences of embodied gender identity, in which there is an interaction between the body (sex) and behaviour (gender). Thus far I have considered some of the complex debates regarding the contribution and sex and gender to the understanding of identity. Indeed I would agree with Woodward (2002:103) that: 'One of the seemingly secure anchors of identity, namely gender as marked by sexual difference has been completely undermined.' Whilst I have considered that sex in terms of biology, and gender in terms of the social construction of identity, are important concepts in relation to understanding reproduction, the notion of embodiment is considered to challenge the dualism of sex/gender and offers an alternative position from which to explore women's experiences of gendered identity. Embodiment is explored next.

EMBODIED GENDER IDENTITY

The process of embodiment offers the opportunity to explore the issue of gender identity in relation to how women develop an understanding of the self through their own bodily experiences. Underlying this particular discussion is the importance of the 'body' and women's embodied experiences of identity in relation to reproduction, motherhood and midwifery. Woodward (2008:84) concludes: 'Embodiment means that our bodies are who we are and are inextricably linked to an understanding of the self.' The association of femininity with the body has dominated the Western world in which Cartesian dualism advocates the mind/body split; whilst men are associated with the mind and reason, women are connected with the body and emotion. This reiterates the essentialist notions of women as 'Other,' in which the female body is a deviation from the male norm.

Two theoretical positions contribute to this discussion of embodied identity. Firstly, as embodiment is a process of unification between the mind and body, the sense of self and the awareness of the integrity of the body in given situations, Grosz (1994) uses the Möbius strip to propose corporeal feminism in the form of a sexed embodiment, to reposition the body at the centre of the analysis of gender identity. This position is a challenge to Cartesian dualism, in which the three-dimensional strip illustrates the seamless connection between the body; the inside and the outside, and the mind:

The body is a most peculiar 'thing', for it is never quite reducible to being merely a thing; nor does it ever quite manage to rise above the status of thing. Thus it is both a thing and a nonthing, an object, but an object which somehow contains or coexists with an interiority, an object able to take itself and others as subjects, a unique kind of object not reducible to other objects. Human bodies, indeed all animate bodies, stretch and extend the notion of physicality that dominates the physical sciences, for animate bodies are objects necessarily different from other objects; they are materialities that are uncontainable in physicalist terms alone. If bodies are objects or things, they are like no others, for they are centers of perspective, insight, reflection, desire, agency.

(Grosz 1994:xi)

The inside and the outside are linked; the body as both boundary and surface. The body is as much social and cultural as it is personal; Grosz proposes the departure from the focus on sexual difference to the reappraisal of the subjectivity of the female body and the embodied experiences of women.

Secondly, phenomenological approaches to the study of the 'lived body' are proposed as a way of analysing the relationship between gendered bodies and experience, and the

ascribed meanings derived in relation to identity. By drawing on the work of Merleau-Ponty (1962) and de Beauvoir (1953), Moi (1999) proposes the concept of the 'lived body', which is not biologicistic but is encultured within social and cultural practices. Central to this is Merleau-Ponty's idea of 'I am my body' (Merleau-Ponty and Smith 2002:202) this presumes that the embodied experience of women in different social and cultural situations and the meaning given to the self as a result, occurs in terms of the relation between the body and the environment, in which situation represents facticity (meaningful facts created in relation to the physical and social environment) and freedom (choices made over time). Young (2005:16) clarifies this position: 'The lived body is a unified idea of a physical body acting and experiencing in a specific sociocultural context: it is body-in-situation.'

Embracing the concept of lived body is a means of theorizing sexual subjectivities without appealing to either biological or gender essentialism. Moi writes:

To consider the body as situation...is to consider both the fact of being a specific kind of body and the meaning that concrete body has for the situated individual. This is not the equivalent of either sex or gender. The same is true of 'lived experiences'; which encompasses our experience of all kinds of situations (race, class, nationality etc) and is far more wide-ranging concept than the highly psychologising concept of gender identity (Moi 1999:81).

Since Stone (2007:177) argues that 'our bodies are infused with meaning' our understanding of what it means to be female or male can therefore be shaped in different ways. I argue that the role of choice in relation to Moi's concept of 'body-in-situation' is contested in relation to women's embodied experiences of certain situations, for example domestic abuse or pregnancy and motherhood. To expand on the example of domestic abuse first, Wesely, Allison and Schneider (2000:212) suggest: 'A woman's body is her identity, and she learns that her sexualized body is her value.' Therefore I suggest that in situations such as in abusive relationships, the power exerted by societal understanding of identity, seems more convincing as evidence of the male cultural influence on the meanings of the female body (Irigaray 1985). Lempert (1996:285) considers that the, 'female body is fused with a sense of self and that women's bodies are vehicles through which men try to exercise control of women's identities,' and as a result the abusive relationship is a:

...systematic fragmentation of female identity as lived body experiences for the domestic violence survivors...this destabilization was also appropriated by the women in their attempts to renegotiate their identities. Even at the height of abuse,

some of the women made efforts to enjoy their bodies in ways, which defied patriarchal constructions of female identity... abusers continually thwarted attempts to pursue activities that emphasized their strength, power, and agency (Wesely, Allison and Schneider 2000:219).

The process of revising the meaning of our bodies in relation to our identity is therefore problematic in these situations. As Stone (2007:177) writes:

...one cannot easily choose to revise or discard the meanings one learns to attach to one's being male or female. These meanings are so fundamental to our self-conceptions that we can only with great difficulty imagine them being revised.

I argue here that the notion of the body as problematic therefore emphasises the lack of agency in relation to decisions made about bodies and the construction of self-identity. de Beauvoir (1953) considers that the experience of women's 'problems' is biological enslavement in which women are prisoners of their own bodies. Marshall (1999:69) writes 'Many women and perhaps most feminists will have experienced the pregnant body as involved in a struggle for control.' Furthermore, an attempt to focus on the female body as a site of women's empowerment and emancipation in relation to reproduction and motherhood (Rich 1976) is criticized for being essentialist. However Shildrick (1997:61) calls for new female embodiment to conceptualise women's embodied experiences:

The move towards embodied selves need not entail a new form of essentialism nor a covert recuperation of biological determinism. Rather it celebrates embodiment as a process, and speaks both to the refusal to split body and mind, and to the refusal to allow ourselves to be either normalized or pathologised.

As theories of embodiment have not addressed the issue of women's agency in relation to reproduction and motherhood, Frost (2007:246) offers the explanation that:

Many of the key works are either gender blinkered, or generalise the experiences of women as a unified category - particularly regarding reproduction.

The embodied experiences of sad, pleasurable and painful events can give meaning to different situations, but also illustrate the diversity in individual experiences and its influences on the perception of the self.

The view that the female body is seen as problematic and in need of management promotes the belief that 'women's bodies are presumed to be incapable of men's achievements, being weaker, more prone to (hormonal) irregularities, intrusions and unpredictabilities' (Grosz 1994:14). The patriarchal biomedical approach to the study of the female body as regulated by hormones and constrained within its biological systems

is considered as unpredictable due to its relationship with nature and is viewed with skepticism (Martin 1997). However Reissman (1992) suggests that women themselves have participated in the construction of the body as a medical category, as a means of providing solutions for their experiences. Biomedical surveillance has pathologised the body in such a way that the female body has acquired a deviant identity as opposed to the masculine.

To conclude this part of the chapter, I question the positioning of the body in relation to pregnancy and childbirth. If as Shilling (1993) suggests the body is central to a person's self-identity, what are the implications of pathologising the female body during pregnancy and childbirth, for women's self-identity and transition to motherhood? The implication of this tension is considered in the discussion that follows, in which I suggest that the changing nature of the maternal body contributes ultimately to women's identity. Here I explore the idea that the development of identity around pregnancy and childbirth is driven by the relationship between the socially constructed view of woman and the biological deterministic view of woman as mother through reproduction. The perception of the reproductive body and its implication for the development of identity in relation to reproduction and motherhood is examined below.

Pregnancy and childbirth

Discourses on childbirth adopt different and polarized views of the female body in relation to pregnancy and childbirth; the technocratic medicalised discourse on one hand and the holistic 'natural' discourse on the other. Firstly, within contemporary systems of maternity care, Davis-Floyd and Mather (2002) discuss the separation of the body from the mind and consider that the technocratic model defines the body as machine in which it sees 'the female body as inherently defective and dangerously under the influence of nature' (Davis-Floyd and Mather 2002:500). For example, Martin (1992) suggests that the doctor is the mechanic that fixes the machine. In relation to menstruation, Martin (1992) suggests that it is considered as the product of failed production and 'a sign of failure to conceive' (Young 2005:102). The descriptions of bodily processes such as menstruation and fertilisation illustrate the focus on mechanical production and the systematic control of actions. Martin (1997:30) writes:

Perhaps one reason the negative image of failed production is attached to menstruation is precisely that women are in some sinister sense out of control when they menstruate. They are not reproducing, not continuing the species, not

preparing to stay at home with the baby, not providing a safe, warm womb to nurture a man's sperm, I think it is plain that the negative power behind the image of failure to produce can be considerable when applied metaphorically to women's bodies.

Since women's bodies leak; blood, mucus, breast milk, surveillance methods initiated during pregnancy focus on the detection of abnormalities in the maternal body and in the developing fetus. Within this context the female body is objectified. Embodied experiences of prenatal technology such as screening and diagnostic methods considers the 'good' female body as a valued 'foetal environment' (Ettorre 2002:86). For those who do not produce normal babies Ettorre (2002), drawing on the work of Landsman (1998), writes:

we live in the 'age of perfect babies' ...mothers of disabled children are seen as producers of defective merchandise; their pregnant bodies, as embodiment of motherhood have failed to follow the culturally appropriate trajectory (Ettorre 2002:86).

The tension here gives rise to the discourse of shame (Ettorre 2000), in which the gendering of shame as a female emotion drives women to judge their bodies in relation to whether they possess good or bad reproductive bodies (Ettorre 2002). In this context, the embodied experience centres on the understanding that the body is flawed and does not conform to the societal norms of reproduction. Moreover, women who experience abnormalities or loss, such as miscarriage, occupy problematic bodies. Frost (2007:250) drawing on the work of Shildrick (1997:179) argues:

Miscarriage is not viewed as an isolated event, but rather as symptomatic of the leakiness of the category 'mother' and women's reproductive experiences more generally.

It is the deviant body that also contributes to the loss of identity as mother in the case of miscarriage. The deviant body in this context is also a stigmatised body in which its need for intervention is a source of embarrassment and shame thus demonstrating its faulty nature.

The body described during medicalised labour is unruly and is subject to management and control. Labour and birth is confined and managed according to the clock in which phases of labour are closely timed. The body in labour requires intervention if it does not conform to 'obstetric norms.' Stewart (2004:32-33) supports this point and writes:

Regulation of women's bodies, through each stage of their reproductive lives, can be seen as an effective way of reminding women of their powerlessness in the face

of patriarchy (Helman 2000). Perhaps this is nowhere more clear than in the control exerted over women's bodies during pregnancy and childbirth.

Terminology used during labour reflect the focus on the body as lacking, not to be trusted, indicated by the use of phrases such as 'incompetent cervix' or 'failure to progress'. This presents the body as ambivalent, suspicious and in need of assistance. This is also a prominent theme within the breastfeeding experiences of mothers. Dykes (2006:168) concludes from her ethnographic study of women's experiences of breastfeeding, that the relationship between the mother and her body is also ambivalent in which the body is considered as a machine. She writes:

their bodies as a means of production...yet they seemed to be strangely alienated from the product, describing to me a striking lack of trust or confidence in her body's ability to 'produce' milk.

One explanation for this may be that the mother's distrust of the body's abilities is symptomatic of the technocratic system within which maternity care is situated. For some, the control and management of breastfeeding, - the 'production process'- is held by midwives, who provide the support and guidance deemed necessary for the development of the skills for successful breastfeeding.

The literature on embodied experiences of motherhood convey 'One example of identity where it would be very difficult to fail to have some regard for the body is motherhood' (Woodward 2002:128). Rich (1976) considers the tension between the control of the pregnant body as institution controlled by patriarchal regulatory policies and practices and motherhood as experience. The transition to motherhood is reflected in the transforming pregnant body. Shilling (1993:65) argues that:

The body offers potential boundaries to the self and presents both the uniqueness of each individual and a site for the marking of difference.

The transforming pregnant body brings with it ambivalence in relation to the changes in body shape, weight and in the inscribing of stretch marks which act to corporeally define the body. Practices of dieting and exercising during pregnancy constitute body management projects (Davies and Wardle 1994) in which some women may strive to retain their pre-pregnant identity and may be associated with the level of control that women apply over their pregnant bodies. However, Young (1984:46) considers the blurring of boundaries of the pregnant body and writes that the pregnant woman:

...experiences her body as herself and not herself. Its inner movements belong to another being, yet they are not other, because her body boundaries shift and because her bodily self-location is focused in her trunk in addition to the head

The second of two discourses focuses on the holistic 'natural' approach. Davis and Walker (2009:3) in the study of case loading care in New Zealand consider the work of the midwife in promoting the normality of birth during the antenatal period and consider the 'maternal body as competent.' Discourses of natural childbirth have considered the instinctive natural adaptation of the body to pregnancy and childbirth and as a result have been criticized for promoting an essentialist position which some women may not achieve. It is argued that in this way they have attempted to challenge 'the construct of the faulty female body, valorizing rather than disparaging childbirth and proffering a feminine corporeal experience' (Davis and Walker 2008:3). Whilst midwifery models of care promote choice and control within childbirth, the positioning of the body within the wider technocratic approach questions the degree of agency exercised in relation to the construction of identities. Woodward (2002:132) writes:

Childbirth and the demand for control over fertility have significantly been expressed as the need for women to control their own bodies. This control of the body, in particular the control of the reproductive body is of special significance to women because of their role in the reproductive process, notably as having the body that bears the child. Control of the body is closely connected to the agency that we can or cannot exercise over our identities. For women this concerns the choice *not* to be a mother, as well as the circumstances in which they can mother.

The tension between the technocratic model of the deviant, unruly and problematic body is compared with a more holistic model, which focuses on the physiological ability of the body as capable and strong.

Within the first part of this chapter I have examined the complexity that surrounds the definition of gender identity and demonstrated the problematic relationship between biological sex and gender. Gender identity is considered as embodied in terms of the experiences of women in relation to reproduction and motherhood; it is clear that the female body occupies a deviant and unruly position, which appears to reflect the practices within the dominant technocratic model of care within the maternity services. The consequence of this positioning is the relationship between women's perception of their bodies and their construction of identity, in terms of occupying either good or bad reproductive bodies. The problem that arises here centres on the question of whether social constructionist accounts explain the primacy of gender differences and of the body

in the experiences of motherhood. Against this background I consider the extent of the relationship between midwives and mothers in this experience.

GENDER IN MIDWIFERY

Gender, defined earlier in this chapter as a key dimension of identity (Järviluoma, Moisala and Vilkkö 2003), is central to both the understanding of the way in which midwifery is perceived and the philosophical beliefs which underpin care around pregnancy and birth. Female dominated professions such as midwifery presuppose the essentialist notion of women as caring, emotional and sensitive. Midwifery presents the opportunity to question the relationship between the contributions of social construction of identity and also the discourses of nature, which centres on the wider debate of the category woman and the essentialist notions that all midwives as women will share similar attributes to care. If gender is central to the identity of midwifery then it is reasonable to suggest that midwifery work is an example of doing gender. The claim that midwifery is women's business may be a nuanced attempt at 'doing gender' (West and Zimmerman 1987), in which the actions of midwives marry with those actions expected of their gender role and are therefore displayed within day-to-day behaviour. In terms of feminine characteristics, gender is seen to be performed in action and interaction. Therefore its subjective experience is important in terms of what it means to be a woman.

By drawing on this theoretical discussion, the next part of this chapter analyses the role of gender within midwifery as a means of theoretically addressing one of my research questions 'How is the identity of the midwife constructed?' The importance of a midwife as a woman, and what is it about a woman that is important in relation to the care of women around birth will be discussed. Since the implications of gender for the identity of the midwife and to midwifery merits further analysis in relation to the focus of my thesis, I will examine gender in relation to two main aspects; firstly the identity of the midwife; secondly the concept of midwifery care.

Gender and the identity of the midwife

Although gender has been considered within the wider debate of gender and nursing (Miers 2000; Hallam 2000), it has been under researched over the last decade in relation to midwives, with only sparse contributions on issues such as sexuality (Walton 1994) and male midwives (Lewis 1991). Some attention has been placed on the gender of birth

attendants in which writers have argued that only women should care for women at birth (Howell-White 1997; Lay 2000). The claim that the motivation and commitment to midwifery care is instinctive rather than socially constructed may be considered in relation to the idea that birth is exclusively women's business, appealing to the functionalist sex-role theory of predetermined attributes. If midwifery has essentialist notions linked to embodiment, it is presumed therefore that only women have knowledge and understanding of reproduction and childbirth to care appropriately for women because of their biological sex and personal embodied experience of pregnancy, birth and motherhood. This is also supported by women's association with 'nature' and the understanding of midwifery as dirty work (Callaghan 2007), in which midwives are concerned with controlling and cleaning bodily fluids associated with birth. The midwife in this context is a 'dirty worker' protecting others from the dirt. However, dirt in childbirth is considered in relation to the power relationships between midwives and obstetricians and midwives and mothers. Those who do dirty work are seen as subordinate. Callaghan (2007:230) suggests:

...regardless of what women do or achieve they will always be the dirty workers, and seen as the most appropriate group to the dirty work related to the home and the body.

Whether it is an explanation for the large numbers of female midwives or not, the social identity of midwifery in this context is developed on the basis of the 'cultural negotiation of gender' (MacDonald 2007:8) in which there are gender expectations of midwives and of midwifery as women's work. The gendered characteristics of birth as something women do, rather than something that happens to them cannot be fully supported within the current technocratic system of hospitalised birth in the UK. Increasing rates of caesarean section is evidence of the interventionist approach that dominates women's experiences of childbirth (Nilsson and Lundgren 2008) and is part of the subsequent dissatisfaction experienced by midwives (Curtis, Ball and Kirkham 2006a; 2006b; 2006c).

The assumptions upon which this claim is based merits further exploration; firstly, it expects that midwives will desire motherhood and will be able to become biological mothers; and secondly that this embodied experience will be of some benefit or value to midwives' practice and the quality of care provided. In terms of the first point, work by Bewley (2000a; 2000b; 2009) and Rowan (2003), not surprisingly, illustrate how midwives occupy different reproductive biographies in which midwives also experience infertility,

pregnancy loss, or they may choose to remain childfree. The literature suggests that midwives who experience infertility find questioning by mothers intrusive difficult and upsetting (Rowan 2003). Walton (1994:114) states that; ‘...to work with babies day in and day out can almost be like rubbing salt in the wounds.’ The emotional trauma for women as midwives has been underestimated and to an extent is encompassed within the wider discussion of emotional labour, which will be discussed later in this chapter. However, the issue of the social acceptability of midwives’ responses in Bewley’s work concurs with Rowan’s (2003) findings, in which midwives who are infertile are made to feel awkward and inadequate, especially because of their daily contact with pregnant women and mothers. The social construction of midwifery as women’s business creates conflict for those midwives who find difficulty in becoming biological mothers. Bewley’s (2009) most recent study of midwives experiences of reproductive loss reported that midwives had a greater understanding of the impact of pregnancy loss and found that they could offer support to colleagues in similar situations. Similarly, in a study of midwives embodied experiences of breastfeeding, Battersby (2009) reports a range of emotions. Some midwives found the positive experience of breastfeeding useful within their professional practice, whilst a small number found that it made no difference. However, midwives, who experienced difficulties, reported a great deal of guilt, which led to the suppression of emotions. Some tentative conclusions can be drawn here; if midwives as women present with varying reproductive biographies, then it could be argued that the experience of pregnancy and childbirth although desirable, is not an essential aspect of the midwife’s identity. Furthermore the influence on practice of embodied experience is personal, which is couched within the midwife’s understanding of professional identity and also the significance of the experience to the individual as an emotional event. This is further explored in relation to the accounts of midwives’ reproductive experiences discussed in Chapter 5.

Furthermore, by accepting this point, it is possible to consider that the position of male midwives and non-mothers within the midwifery profession is rather difficult. By privileging women as midwives, and also as mothers, midwifery would be open to claims of discrimination both from non-mothers and from men. Based on the biological essentialist claim, there is the assumption that men do not have the instinctive capacity to care and have no place within natural normal childbearing but assume a higher status as doctors. Although there has been a dearth of recent research on male midwives, work

by Williams (1993) and Simpson (2009) on men in non-traditional occupations, present an interesting debate around men's use of emotion and the use of skills traditionally attributed to women alone. Men in female dominated caring occupations such as in the care of older people for example, do display skills and personality traits expected of women (Applegate and Kaye 1993). Anecdotal evidence from mothers in relation to their experience of male midwives suggests that gender and the associated embodied experience is of little significance to the care provided.

To counter the claim of a gendered approach to care, I argue that not all midwives perceive reproduction and childbirth in the same way and may not share the same ideological approach to birth or occupy the same emotional space. Hunter (2004a) reported the conflicting ideologies in relation to the location of care. Midwives working in hospitals were more inclined to adhere to the occupational ideology of 'with institution' where 'a medicalised approach to childbirth appeared to dominate hospital midwifery practice' (Hunter 2004a:267); whilst midwives working in the community adhered to a 'with woman ideology' in which they supported a more holistic woman-centred approach emphasising the psychosocial and physiological approach to birth. Therefore the institutionalisation of midwifery and the socialisation of midwives influence the philosophy of midwifery and as a result the identity of the midwife; so much so that it could be argued, that midwifery may have lost its original identity of 'being with woman.' In spite of revolutionary policy changes such as Changing Childbirth (DH 1993), the notion of midwifery as women's business and its practice in that context is strongly determined by the current organisation of maternity and women's services which reflect an overarching paternalistic technocratic approach (Walsh 2007a). Midwifery skills associated with traditional midwifery such as nurturance and support are replaced with the use of interventions and rising caesarean section rates. Therefore the location and organisation of maternity services, it could be argued, does not only influence the provision of care but also the meaning of midwifery in relation to its gendered associations with nature and normality.

Although some midwives maintain a very strong holistic philosophy of midwifery, others adopt a more technocratic approach. Midwives who practise within the medical model may experience difficulty when it does not reflect their philosophy of normal birth. Russell (2007) reported that midwives who attempted to maintain clinical autonomy

within an Obstetric led unit were labelled as 'mad' or 'bolshie' by obstetricians. Indeed the development of strategies such as staying in the labour room to protect the mother from intervention is not uncommon and widely reported in the literature (Hunt and Symonds 1995; Anderson 2002; Crabtree, 2004). In this context the actions of midwives can be viewed as 'resistance' in which they promote the identity of the midwife as protector and as a practitioner of normality within a dominant hierarchical system.

Midwives may also seek out employment within locations of care that reflect their personal philosophies, personal identity and practice as practitioners; others may through a process of socialisation, develop different philosophies of care, based on the location of practice. For example, the provision and philosophy of midwifery care differ greatly between a Consultant unit and a freestanding low-risk birth centre in terms of the models of midwifery employed (Walsh 2007a). In the Consultant unit the technocratic model of birth exists in which childbirth is normal in retrospect. Midwives may be technically skilled in relation to high-risk obstetric care but may be less inclined to support normal physiological labour due to a lack of confidence and skills. Alternatively, in the birth centre, a holistic social model is employed in which the midwife can use her skills rather than depend on technology. The birth centre environment is considered as a second home (Walsh 2007b), which rejects the suggestion of institutional care and embraces intuition and emotion. If, as MacDonald (2007:60) asks in her ethnographic study of midwifery in Canada: 'Ought midwifery be constructed as the re-emergence of an ancient tradition of women helping women in childbirth?' the emphasis on the nature of midwifery knowledge in this context, embraces a midwifery philosophy that honours women's ability to birth in which there is a clear understanding and commitment to holistic midwifery and how it should be practiced.

In a study of the experiences of midwives participating in a caseload practice (CLP) scheme, midwives who had previously found the existing service frustrating were now in a position to consider midwifery in a more holistic way. Stevens and McCourt (2002:115), report that midwives evaluated their experiences positively in which it was felt that, the scheme:

..forced them to reassess and reconceptualise their role, but it produced strong perceptions of the meaning of being a midwife. In talking about being 'a real midwife' they referred to the value of psychosocial and woman-centred care, as well as the application of clinical skills. It was clear that the midwives saw continuity

as important for the mother, but equally, as important for themselves in learning and developing their role.

What is clear here is that the reference to a 'real midwife' acknowledges that there is a clear definition of what a midwife is or should be but the location of care may support or restrict the way in which the midwife can realise that identity; midwives acknowledge what midwifery is and what it is not.

By assuming that midwifery is women's business, it is also assumed that midwives hold the control of the provision of care, although this is rarely the case in midwifery within the NHS. The position of gender here reflects the social construction of caring as a lower status activity, either within the home or in a public capacity, in which care is based on instinct rather than professional knowledge and education. The issue of gender within caring occupations has been the focus of much debate due to the issue of power and gender inequality within healthcare. Miers (2000:127) writes:

Women's responsibilities for care have been seen as constraining and controlling women by denying them equal opportunities in the labour market, In the workplace, caring activities, defined as emotional labour and emotion work, are unrecognised and unrewarded because they are seen as women's natural skills, emanating from the domestic sphere.

The assumption here is that by referring to midwifery as women's business, midwives and mothers attempt to promote the re-emergence of midwifery as 'an ancient tradition' (MacDonald 2007:91). This does not just reassess the use of technology within childbirth and the demise of 'normal' birth but also of midwife's skills in supporting mothers to have a satisfying experience. Emphasising gender difference is a way to reclaim a sense of identity.

This claim can also be considered in the wider context of women's lives. I argue here that that the notion of reproduction and childbirth as 'women's business' may be considered as false since Earle and Letherby (2003:2) write:

It is commonly assumed that the issue of reproductive health is women's business' and, arguably for some women, this assumption has been instrumental in their control over reproduction...we would deny the personal and political significance of this viewpoint, we would argue that it can obscure the fact that the majority of women do not make reproductive decisions in isolation from other people; they make them within the context of intimate relationships and professional encounters – often with men.'

Whilst women have maintained some control over their fertility, others argue that it is at the hands of medical doctors. Recent developments in fertility treatments are developed with the purpose of enabling women to become mothers. However, the advancement in reproductive techniques in relation to post-menopausal women can also be viewed as paternal experimentation and an extension of medical control.

The examination of the professionalisation of midwifery raises the issue of the association between gender and class in relation in midwifery in terms of the fact that only good women could become midwives. The social construction of the identities of the lay handywoman or 'Goodwife' as the working class provider, and that of the middleclass professional midwife, presents a useful case study for the analysis of embodied gender identity in relation to my research. At the turn of the twentieth century, the transition from the lay 'handywoman' to the professional midwife in England was a historic moment in the campaign to regulate the training and practice of midwives and improve standards of care. Although it was seen as a political move instigated and controlled by the medical profession as a way to reduce the high level of maternal mortality (Trowler and Bramhall 1986; Field 1990) attributed in the main to the poor practices of the lay handywoman, Leap and Hunter (1993) suggest that little evidence was produced to support this claim. In fact, in spite of the training of midwives and the provision of care in hospital care deemed to provide additional safety around birth, maternal mortality rates increased between 1924 and 1936; the provision of hospital care jeopardized the health of women in childbirth due to the presence of infection.

The identity of the handywoman as compared to her middle class counterpart was embodied by Charles Dickens character Sairey Gamp as 'sloppy, dirty, drunkard and hired attendant of the poor' (Leap and Hunter 1993:6). Many handywomen were paid for laying out the dead. The association between birth and death reminds us of Callaghan's (2007) discussion of birth dirt and the link with leaky bodies. Attending the dead was considered to be dirty work as it was thought to contribute to the spread of infection. Unfortunately this characterization was used to discredit the handywomen and to support the professional regulation of midwifery. Leap and Hunter's (1993:22-23) oral history research of retired midwives, describe the handywoman in a different way:

Written accounts of the day, plus testimony that we gathered, suggest that individual handywomen varied as much as individual midwives in terms of whether people saw them as 'good' or 'bad'.

Handywomen were described as older motherly women, most of whom had their own children. Skills were passed down from mother to daughter and in this way experience was considered more important than education. However, many accounts describe the handywomen as illiterate. Moreover, the Midwives Act 1902 saw the demise of the lay handywoman and marked a class difference between handywomen and the middle upper-class midwives who sought 'professionalisation'. These midwives were 'well-connected with social reformers, politicians and medical men' (Mander and Reid 2002:3), and through the Midwives Institute (formally the Matron's Aid Society and later to become the Royal College of Midwives), advanced their agenda of finding jobs for middle-class educated women.

The focus on good character can be seen to reflect not only a personal identity but a professional identity too. The introduction of the Midwives Act of 1902 allowed any woman of 'good character' to be registered, following at least one year's practise before the Act. The regulation of the profession was considered necessary to develop midwifery as a respectable occupation thus removing the previous negative connotations associated with the profession and to recognise women's skills and expertise. It could be argued that the professionalisation of midwifery changed the focus of the nature of midwifery knowledge from maternal nurture to medical midwifery knowledge.

Within contemporary midwifery there is emphasis on the character of the midwife (NMC 2008a). Midwives' professional identity is therefore socially constructed in terms of social expectations of behaviour and expertise. Moreover, it is professionally constructed through a process of professional socialisation defined as a mechanism whereby '...the surrounding culture and value system teach the individual the appropriate patterns of acting and thinking' (Symonds and Hunt 1996:5). Whilst the procedure of signing a declaration of good character at registration is the responsibility of the Lead Midwife for Education, drawing on historical perspective there is an assumption here that only good women can become midwives and that only good midwives can care. I discuss this further in relation to midwifery care in the next section.

Gender and the provision of care

This discussion will centre on the analysis of the relationship between the essentialising of feminine characteristics, in terms of the notion of 'women as midwives, undertaking 'women's work' (Kent 2000:73) and the concept of care within midwifery as a feature of

femininity. Although there is a generic social and cultural understanding of what femininity is in relation to female behaviour and qualities, it is relevant to argue that there are different categories of femininities (Holland 2004). In accepting this then the possibility that care will be offered in different ways in which the midwife as a woman will draw on her own social, cultural and embodied understanding of femininity must be considered. In the analysis of the relationship between gender and the provision of midwifery care, it is important to consider that gender is a source of power and that care based on specific gendered expectations may be empowering and equally disempowering, if not exercised to meet the needs of individual women.

Swanson (1991) defines caring as 'a nurturing way of relating to a valued other towards whom one feels a personal sense of commitment and responsibility' (163). Her theory was developed from the results of three perinatal studies and illustrates the importance of five interrelated processes that characterise the meaning of care; knowing, being with, doing for, enabling and maintaining belief. I suggest that these processes reflect the midwife's role in the provision of individualised woman-centred care and forms the basis for the discussion and analysis of the gendering of midwifery care within this thesis. As a result, I examine the provision of midwifery care in relation to the three key points. Firstly, knowing and understanding; this is formed from the process of engagement and this process cannot be achieved unless the midwife is prepared to understand the meaning of the experience for the mother. The relationship between the midwife and the mother in this context is one that centres on the relationship between women, and the view that birth is a wholly feminine experience. Carolan and Hodnett (2007:146) suggest that this relationship between women may:

...foster a sense of belonging and continuity which harks back to earlier simpler times when, traditionally childbearing was the province of 'wise women' within the community. As such birthing knowledge, as the 'property' of women was handed down from generation to generation.

Mander (2001:8) also considers care in relation to the engagement between midwife and mother and defines midwifery care in relation to support; this refers to the provision of emotional support which may include 'demonstrating concern and intimacy', instrumental or practical support, informational and esteem. Care in this context reflects the principles of woman-centred care (DH 1993), in which support is an integral part of the partnership approach (Pairman 2000). Establishing a partnership that is a dynamic contract between the midwife and the mother requires an exchange of trust and

knowledge; the potential holistic nature of this relationship facilitates the empowerment of the mother during the childbearing process, and is a direct challenge to the patriarchal system of care. Whilst the emphasis here is on empowerment as part of the philosophy of woman-centred care, unless the midwife is herself empowered she may be unable to empower others in her care. Many have supported this approach of mutual understanding between midwife and mother. Kirkham (2000: xiii) suggests:

...historically and usually today, the midwife is a woman, and this is a relationship developed and defined as one between women. Both women relate to their roles, as childbearing women or as woman providing professional care during childbearing.

Both Leap (2000) and Wilkins (2000) focus on the use of both professional and personal knowledge in the process of engagement with mothers and focus on the intuitive nature of understanding. The relationship is considered to be the distinguishing feature of midwifery, which promotes job satisfaction for midwives (Kirkham, Morgan and Davies 2006) but also a key to the quality of care for mothers (Hodnott 2002; Edwards 2005).

Secondly, midwifery care encompasses an emotional presence, facilitated through the use of compassion and empathy as features of caring behaviour. Swanson (1991:163) describes this process within her theory as '...becoming emotionally open to the other's reality. The message conveyed through 'being with' is that the other's experience matters to the one caring.' An emotional presence can be viewed as a relational process, in which the midwife is considered as a professional friend (Walsh 1999) or a companion (Lundgren 2004). Wilkins (2000) considers that emotionality, together with mutuality and familiarity, are key aspects of a close personal relationship between midwife and mother. This emotional presence is also a process of engagement with women and can be rewarding for midwives within a framework of continuity (Deery 2009). Emotion can also be considered as support (Mander 2001); Hodnett et al., (2007) suggest that the provision of emotional support can have a positive influence on birth outcomes. Meeting the emotional needs of women demands sensitivity and intuitiveness from midwives, in which subtle signs from women can suggest the level of emotional care they require (Leap 2000).

The expectation that midwives will be emotionally engaged and empathetic, reflects the social expectations of women as carers, in which caring is emotional and instinctive. In this way, care is a gendered female skill that contributes to the inferiority of women. The

original work of Hochschild (1979; 1983), who studied the way in which flight attendants displayed and managed their emotions in the workplace, is relevant to this discussion. Hochschild (1979) drew attention to the ways in which individuals use their emotions to achieve socially acceptable emotional responses. This was achieved by the use of feeling rules (Hochschild 1979) that relate to the emotions that should be displayed and felt in given circumstances. She used the term emotional labour to describe the public display and management of emotion, whilst emotion work was conducted in private (Hochschild 1979:1983). Hunter (2004a) proposed that the use of the term emotion work was more suitable within midwifery, since the management of emotion occurs in the context of the caring environment of hospital and home, and reflects the role of the midwife as carer, which is in contrast to that of the flight attendant described by Hochschild.

Whilst successive researchers have examined the processes involved in the adjustment and expression of emotions in relation to the healthcare workplace (Bolton 2005), an increasing number of studies have emphasised the complexity in relation to the degree of emotion work within midwifery care (Hunter 2004b; 2005). This is particular to the overwhelming demands of both the organisation and colleagues (Hunter 2006; Deery 2009; Dykes; 2009); others have reported the dangers of emotional suffering in relation to midwives' management of emotional work within a woman-centred approach to care (Leinweber and Rowe 2008). The emphasis on emotion work (Hunter 2005) has been discussed in relation to the management and performance of emotions in which midwives use strategies of 'putting on a front' (Deery 2009), to control the extent of emotional engagement. Therefore as Hunter (2004b) emphasises the need for midwives to develop emotional intelligence as a means of becoming more emotionally aware of mothers needs and of their own, the claim that care embodies innately feminine features such as emotion becomes more problematic. This is evidenced by the increasing literature on the difficulties of managing emotion; the concept of 'cost of caring' is variously described as compassion fatigue (Thomas and Wilson 2004), post-traumatic stress disorder (Weathers and Keane 2007), secondary traumatic stress (Figley 1995; 2008) and vicarious traumatisation (Thomas and Wilson 2004). The balance between maintaining emotional engagement as a way of meeting the needs of individual women and emotional detachment as a means of controlling the demands put upon midwives of working with women, reflects the problem of the location of midwifery care. Within the contemporary provision of maternity services from within hospitals, systems 'privilege

technology over care' in which '...status comes with technical rather than caring work' (Kirkham 2009:232).

Thirdly, I suggest that the concept of matrescence is a thread throughout the dimension of doing for, enabling and maintaining belief within Swanson's theory of caring. This aspect of care is particularly significant in the context of my research, as it focuses on the maternal nurturing qualities of comforting, protecting, preserving dignity and creating an environment that supports the transition of becoming mother. 'Enabling means providing support in the form of allowing and validating the other's feeling' (Swanson 1991:164). However, whilst matrescence, like presence, (Pembroke and Pembroke 2008) can be defined as a process of spiritual becoming (Thomas 2001), care in this context is seen as both spiritual and nurturing, as well as encompassing the physical aspects that promote comfort. In this way matrescence is as much an attitude to care, which is manifest in environments that promote the physiological aspects of normal birth, as it is an aspect of midwifery care. However, the relationship between matrescent care and gender is more problematic as it essentialises care as a female activity. This may be a particular challenge for male midwives as Walsh (2006:237) suggests that:

...'matrescence' is a better term than 'maternalism', as the latter is laden with this gender baggage,. I understand matrescence as a skill in facilitating the becoming of a mother, which has generic application to either gender

Whilst matrescent care may also indicate a feminine spirituality around birth, Hall (2001) concludes that issues of spirituality in care should be considered on an individual basis, rather than in relation to a specific gender. The association between matrescence and mothering therefore in relation to the analysis of midwifery care is more complex, as skills of nurturing may be more socially and culturally developed rather than gender specific. Mothering qualities have been considered to be a specific aspect of the empathetic approach to care (Walsh 2006). Pembroke and Pembroke (2008:2) write:

A caring presence involves creating an environment of trust and security...The caregiver is like a mother in that she creates a warm presence amidst the frightening realities that the patient or labouring woman must face.

The provision of matrescence as a dimension of care and as a rite of passage may be more of a challenge within certain locations of care such as within hospitals as a result of the philosophy of care rather than gender of the midwife. Walsh (2006) describes the concept of matrescent care as a dimension of birth centre care and is bound by the midwife's ability to be emotionally aware of the woman's needs.

CONCLUSION

This chapter has demonstrated the complex nature of the debates concerning gender and identity in relation to reproduction, childbirth and motherhood. The theoretical debates of social construction and biological determinism illustrate the complexities in relation to definitions and descriptions of identity and raises questions of the contribution of embodiment, which may be more important than biology in relation to the focus of this research. Midwives are bound up as women and in their work with women in these problematic debates. Because the focus of this thesis is on reproduction and childbirth, gender identity and embodiment are central to reproductive experience and childbirth for two main reasons. Firstly embodied gender identity focuses specifically on experience and how the self can be defined in relation to those experiences irrespective of gender and biology. Secondly, the literature suggests that the notion of the body as problematic, as faulty and deviant, is expressed by the technocratic approach to care, which together with the terminology used within childbirth, emphasises women's lack of agency, and has implications for the construction of self-identity in relation to motherhood.

Identity in this thesis is construed as a process of identification; gendered identity that focuses on women is key to identification and the way people make sense of themselves, not on the basis of the essentialist notions of the category woman but on the identification of sameness and difference. Identities therefore can be accommodated on the basis of sameness and difference although this is contradictory since we have multiple identities.

The significance of gender identity within midwifery is considered in terms of essentialist claims that caring occupations are established on the basis of the relationship between caring work and femininity. In accepting that there are categories to femininities and masculinities it is reasonable to assume that attributes which are useful in the care of mothers around birth may not be exclusive to women. Whether midwifery care upholds aspects of social and cultural expectation of femininity or not, the literature suggests that the expectation of care around birth is one which is influenced heavily by the location of midwifery services. The implications of binary positioning and the essentialising of feminine characteristics within the notion of midwifery as women's business, raises a number of issues that contribute to the subjugation of midwives within technocratic

maternity services. Reproduction and reproductive work is a potential site for the oppression of mothers and midwives as women. Whilst midwives draw on gender to support the dynamic elements of woman-centred care around birth, emphasising care as a wholly female activity may act to restrict and confine midwifery within technocratic systems. Moreover, midwives' scope of professional practice promotes midwives as 'guardians of normality' (Rosser and Anderson 1998:4), although the opportunity and desire to practice midwifery in a physiological context in hospital settings is problematic.

The next chapter is the first of two methodology chapters in which I develop a feminist theoretical position to show how women's experiences are a legitimate source of knowledge. This chapter contextualises my situatedness as the researcher, and through the discussion of my biography, enables further understanding of my interaction with the research respondents and also the way in which my biography plays a part in guiding the research to address the aims of the study. This is explored in relation to the application of an auto/biographical approach and the use of Gadamerian phenomenology, which enables the experiences of women to be heard. This is further elaborated in Chapter 3 when I discuss the process and practice of conducting the research with midwives and mothers using this approach.

CHAPTER 2

THE SITUATED RESEARCHER

INTRODUCTION

This is the first of two methodology chapters, in which I aim to make explicit the importance of the relationship between myself as researcher and the research considered in this thesis. Since methodological issues are central to this thesis, it is necessary to consider this discussion here for three reasons. Firstly, it is crucial to the appreciation of the application of an auto/biographical approach within a feminist context, within which my biography is embedded. Secondly, this discussion contextualises the key concepts considered in Chapter 1 and further develops the theoretical framework. Thirdly, this chapter locates the theoretical and methodological relevance of the methods used within this research and acts to form a foundation for the methods discussion in Chapter 3.

The purpose of this chapter therefore is to situate myself as researcher in relation to the key theoretical and emerging methodological issues that underpin this thesis. Drawing on a feminist epistemological framework, I begin by detailing my biography to illustrate my positioning as researcher; firstly in relation to my experiences of pregnancy, childbirth and motherhood and secondly in relation to the aims and research questions of my project. I provide the reader with a rationale for the application of an auto/biographical approach; an overview of my experience as a midwife and a mother is presented as a means of illustrating how my autobiography is key to the focus of the research.

I develop this discussion further to present the theoretical framework that underpins this thesis. I focus on a Feminist epistemological position that draws on aspects of Feminist Standpoint Theory. I critically consider the feminist epistemological debates in relation to the nature of knowledge and knowledge production to include situated knowledge and theorised subjectivity (Letherby 2003). Following this, I further develop the discussion to encompass specific concerns that focus on the key theoretical aspects of adopting an auto/biographical approach in relation to the concept of positionality and reflexivity; significant aspects of my biography are interwoven within this discussion to illustrate key points. In addition, I consider some of the challenges that adopting such an approach present to the production of what Stanley (1999) refers to as accountable knowledge.

In the development of an appropriate and suitable methodology, the central principle of this thesis as previously stated, is the acceptance of the researcher as a central character within the research process. Influenced by the philosophy of Gadamer I conclude this chapter by discussing the justification for the use of an interpretive research approach guided by Gadamerian hermeneutic philosophy (Fleming, Gaidys and Robb 2003). Within this, I consider some of the feminist debates in relation to Gadamer's philosophy, to demonstrate how the interaction between feminist theorising of auto/biography and Gadamerian philosophy. I support the application of a reflexive auto/biographical position and develop a relevant analytical approach to the analysis of the twenty-seven interviews. This underpins the method of data collection and data analysis methods discussed in detail in Chapter 3.

INTRODUCING THE RESEARCHER

In this section I aim firstly to present an account of my experiences during the early part of my pregnancy followed by an overview of my childbirth experience, which are both triggers to my work in this thesis and are deeply implicated in its theoretical and methodological development.

To situate myself, I am a forty-six year old married woman and a mother of a 12-year-old son. I trained as a nurse in London in the mid 1980s and completed my midwifery training in 1988. Over the last 20 years, I have worked as a midwife in a variety of different roles, and gained a wealth of experience. Having enjoyed fruitful careers, my husband and I decided to have a baby after five years of marriage. We had in fact been together 13 years before we decided that we were ready to consider the possibility of children. By this time, family and friends had ceased to ask us about the possibility of children as they either concluded that we were unable to conceive or did not want children. However, both of us had always aimed to have children but our careers had taken us around the country we had had little opportunity to settle.

I conceived very quickly and felt very unwell from the 6th week of pregnancy. Since I experienced persistent nausea and vomiting the GP, who I knew as a colleague, discussed the possibility of a twin pregnancy and advised an early ultrasound scan. Attending the ultrasound sound appointment was eventful; as I lay there the sonographer applied the cold gel to my abdomen and ran the ultrasound transducer across it. I looked over at the

screen and saw a black cavity; I could not see any evidence of a viable pregnancy. The sonographer who was also a colleague asked me 'How many weeks are you?' She looked at the screen with a puzzled expression. The tears ran down my cheek. The persistent nausea and vomiting indicated of the presence of Human chorionic gonadotropin (HCG); a hormone which is the basis of the pregnancy test and is detectable in urine and blood within 10 days of fertilisation¹. The sonographer looked at me and said 'I can't see a pregnancy Sarah, we can re-book an appointment for two weeks or we can do a transvaginal ultrasound scan² today'. Without hesitation I agreed to have a transvaginal scan. I looked at my husband and I said to him that I wanted to know one way or another that day. I couldn't go back to work on the labour ward to work as a midwife feeling so unwell and not knowing what was going on. I waited about half an hour and finally had the scan. Whilst I expected to be around 8-9 weeks pregnant, to my surprise and relief my pregnancy was dated as 5½ weeks. I saw this pulsating heart beat on the screen and the tears of joy ran down my face. This was the first experience of many which has influenced my perspectives as a midwife and a mother. Before I explore specific experiences in more detail, I will present an overview of the pregnancy and birth.

I continued to work between labour ward and prenatal screening (one day a week), until I started maternity leave at 28 weeks. At this stage my growing abdomen made working very difficult; driving also became impossible therefore I was unable to work beyond this time. Having been investigated for gestational diabetes and attended an Obstetric Medical Antenatal Clinic, it became evident that the baby was growing very well and many described it as 'a big baby'. As a midwife I was very concerned about the mode of delivery and discussed with the Consultant the possibility of an elective caesarean as I am only four foot eleven inches. As my pelvis was considered adequate, he advised me that a trial of labour would be preferable but he would personally manage the labour and, if any difficulties occurred, a caesarean section would be performed. Following an earlier ultrasound scan, I knew that I was expecting a boy and I had developed such a close relationship with him that I felt that I already knew him. My fears were focused around the increased risk of difficulties during the birth because of my short stature and 'big baby.' I was also concerned about his rate of growth. I was desperate to be induced for

¹ Since Human chorionic gonadotropin (HCG) is produced by the syncytiotrophoblast, which is a layer of the developing placenta.

² A transvaginal ultrasound scan is a scan where a probe covered by a condom, is inserted inside the vagina to provide an image of the uterus and ovaries.

this reason and at 42 weeks I was finally admitted for induction. A week earlier I had arranged to discuss the possibility of an epidural with the consultant anaesthetist, and she agreed to be called once I was in established labour. I dreaded the thought of my baby becoming distressed during the labour and I consistently asked the midwife whether there was any evidence of meconium³. I thought that if my cervix became fully dilated that I would have a problem with the delivery of the shoulders at birth which is an obstetric emergency called shoulder dystocia⁴. I was afraid that as a result my baby would have long-term disabilities or, worse, die at birth. All these thoughts were at the forefront of my mind. After 10 hours in labour with an epidural, the decision was made to perform an emergency caesarean section. I was so relieved to hear those words: I was not frightened any more. I felt now that he would be safely delivered. My epidural was 'topped up' and I was pain free. He was delivered in a good condition, weighing in at 4.330 kg and we were both transferred to the postnatal ward together. On the sixth day Thomas and I were discharged home. Physically I felt very tired and did not regain my level of physical health for a number of months.

At 5 weeks old Thomas was admitted to the local hospital as an emergency with suspected meningitis. He had not fed very much during the previous day and whilst he had no other symptoms, I knew something was wrong. When I woke that morning, he was lying in the cot, pale and still, he had a terrible high pitched cry and immediately I knew he was very ill. I rang my colleague the GP and she was there in 10 minutes. She suspected meningitis and we rushed him to the local hospital with a letter. I thought we were going to lose him. Investigations were started immediately and the care we received was excellent. I slept with him in a side room for five days. My husband visited at lunchtimes and every evening. Both sets of relatives lived away; none of them came up to visit. Although the diagnosis of meningitis was not confirmed and a viral infection was

³ Meconium is a thick, green, tar like substance, which is present in the fetal bowel and is the earliest stool of the baby. In situations where fetal compromise or distress in labour is present, meconium is released from the fetal bowel and contaminates the amniotic fluid. As a result the amniotic fluid is tainted with a green colour.

⁴ Shoulder dystocia is defined as an emergency situation whereby after the delivery of the head, the anterior shoulder most commonly becomes impacted on the maternal symphysis or sacral promontory of the maternal pelvis. This situation requires a range of obstetric manoeuvres to release the shoulders to allow the baby to be delivered. This situation is associated with high maternal morbidity and perinatal morbidity and mortality.

suspected, it did not lessen the guilt that I felt; I felt hopeless as a mother. I judged myself. I felt that I had let him down and that this was my fault for not persevering with breastfeeding. I should have asked for help but I felt that I should have known how to position him; after all I had supported so many mothers with breastfeeding that I felt a failure not being able to do it myself. Following my discharge from hospital, I was visited by a number of different midwives who usually left me to the end of their visits as I lived on the fringes of the county. I felt unable to ask them for help as I knew that they would expect me to know what to do and any expression of needing help would be thought of as weakness. On reflection I should have contacted my colleagues who I trusted to help me or telephone the local Breastfeeding Support Group but I was too proud and too stubborn. I still felt that if I had continued to breastfeed him than he would have developed a stronger immune system and may not have become so ill. Yet Thomas recovered well. As the weeks went by, the feelings of inadequacy eased away and I prepared for his first Christmas.

A heart murmur diagnosed during his admission to hospital was followed up by the Cardiologist in the February and a diagnosis of Patent ductus arteriosus (PDA)⁵ was made. My husband and I refused the surgical correction of this condition which we were advised to consider, on the basis of the outcomes of cases detailed to us by the consultant. Thomas has been well without surgical treatment and during a subsequent consultation, we were informed that surgery was unnecessary. I was delighted 18 months later to be pregnant again, but sadly three days later I miscarried. I have been unable to conceive since that time. Although it has been 12 years since the birth of my son, I am now in my mid forties resigned to the fact that I will not have another baby.

Reflecting on my experiences highlights the emotional upheaval of pregnancy and childbirth. This process of self-analysis has revealed my anxieties about my pregnancy and my fears about experiencing complications in labour. Obtaining a copy of my midwifery obstetric records was an illuminating moment at the beginning of this journey. Reading about my developing pregnancy and my journey through labour from the perspective of others has acknowledged and validated my anxieties that I remember so vividly. In this context, I consider that the process of completing this doctoral research has been both therapeutic and inspirational. However, as I move away from the identity of a

⁵ Patent ductus arteriosus (PDA) is a congenital heart defect.

childbearing woman to that of a pre-menopausal woman, I am distanced from the realities of reproduction as personal experience. In this context my distanced position in relation to reproduction contributes to a process of 'enabling' whereby my biography can facilitate the identification of wider issues within the sociological context of reproduction and motherhood without the personal emotional involvement. This does not mean that I am objectifying my position as the researcher; rather I contribute to the exploration of women and mother's experiences without questioning my own position in relation to reproduction. By drawing upon my embodied experiences of pregnancy and childbirth therefore, I make explicit the extent to which these experiences are embedded within this research and illustrate how I am situated as a researcher in relation to the midwives and mothers who have participated. In the next section, I consider the relevance of these aspects within the wider theoretical framework that underpins this thesis.

DEVELOPMENT OF A THEORETICAL FRAMEWORK

The research adopts an approach that acknowledges the central role of auto/biography to promote the process of understanding, respecting and empowering women through their experiences. Furthermore the biography of the researcher is central to the production of accountable knowledge or unalienated knowledge (Stanley 1990); knowledge defined as that which is clearly produced from the social context and methods used. Stanley (1990:12) states:

...written accounts of feminist research should locate the feminist researcher firmly within the activities of her research as an essential feature of what is 'feminist' about it .

As a result, the use of the term auto/biography reflects the acceptance of the broader analytical meaning of auto/biography as a reflexive process (Stanley 1992), in which the researcher, through the acknowledgement of their positioning, makes explicit the power relations within the researcher-respondent relationship. Using the hyphenated form of the word auto/biography reflects the bond between the distinctive contribution of both the respondents' and the researchers' own stories to the co-construction of knowledge.

Against this background, the theoretical framework used to underpin this thesis appeals to a feminist epistemological position that honours women's experiences as a legitimate source of knowledge. Hughes (2002:151), drawing on the work of Skeggs (1997), suggests that:

...experience has been seen as the basis of feminism in that feminism as a social movement and as a personal politics began the movement that women began to talk to each other and make sense of their experience as women.

This research appeals to three distinct characteristics of feminist research. Firstly, the context of the research is derived from the experiences of midwives and mothers in relation to reproduction; secondly the research contributes to the understanding of identity and gender in relation to reproduction, motherhood and midwifery work. Third, the use of an auto/biographical approach locates the position of the researcher in the same 'critical plain' (Harding 1987:8). The theoretical framework adopted within this research supports an approach that is grounded in the experience of women⁶ who are reflexively engaged in the production of knowledge. Whilst drawing on aspects of Feminist Standpoint Theory (FST) (Harding 1986) offers some useful insights since it foregrounds women's experiences, (which is of interest to this thesis), adopting a theoretical position that exclusively draws on FST is problematic for two reasons. Firstly, a standpoint approach suggests that there is a standpoint that is more accurate than others which limits the standpoint of those others who may not assume such a prominent position. Furthermore, if standpoints acknowledge the association between oppression and knowledge, the resulting position leads to the support of hierarchies of oppression, where the most oppressed are considered to be the most knowledgeable; this is unhelpful and unproductive. Secondly, whilst the issue of knowledge will be explored further in this chapter, it is worth stating here that viewing women as a homogenous group implies a single shared standpoint that does not account for differences between and among women influenced by other dimensions such as ethnicity for example; thus reinforcing gender stereotypes.

To address these points I focus on the theoretical positioning of difference as a way to support my position as a researcher in relation to understanding identity as a process of sameness and difference. For this purpose, the contribution of Feminist Postmodernism (FM) in relation to its position on difference is useful, because difference feminists confirm the position of the body and the notion of embodiment as central theoretical contributions to feminist theory (Davis 2007). For these reasons I assume a midway theoretical position drawing on both the strengths of FST and FM to underpin this research, as a means of accepting the contribution of FST but also as a means of accepting

⁶ This includes the researcher and respondent in this research.

its' inadequacies in representing the diversity and difference in women's position which FM addresses. Whilst I do not present an overview of the differences between FST and FM, it is important to state that I do not appeal to the deconstructivist theories of FM per se (MacKinnon 2000).

The diversification of feminist theory has resulted in 'multiple theoretical perspectives' (Letherby 2003:43). Drawing on the work of Stanley (1999), Letherby (2003:43) argues:

..if we focus on distinct approaches and emphasize their differences we risk dividing feminist explanations into disparate positions, which is inappropriate as it implies mutual exclusivity, where many feminists have sympathies with aspects of each approach.

While some may argue that this is a symptom of the fragmentation of feminism, it is suggested that this signifies not only the development of feminist theory but also represents the development of a methodological and epistemological position that recognises that notions about truth and reality must be considered in relation to the way in which knowledge is produced (Stanley and Wise 2006). In this context I suggest that by moving away from traditional sociological approaches, such as feminist empiricism for example, researchers can explore women's experiences in different social locations. This is a way of not only acknowledging the contribution of the early feminists from the nineteenth and twentieth century's, but a means by which researchers from different disciplines can today develop the foundation of feminist theory to adopt alternative theoretical positions, for example the development of ecofeminism (Warren 2000; Chircop 2008).

Central to the application of a feminist theoretical position is the issue of knowledge and knowledge production. I do not claim to offer a comprehensive account of the academic debate here, as this is a subject of great complexity within the literature; however, I do discuss a position that reflects my thinking in relation to the aims and research questions within this research. In what follows I elaborate the theoretical discussion further by addressing key issues within feminist theorizing; firstly the positioning of women's experiences is considered in relation to aspects of FST; secondly the issue of reflexivity is discussed in relation to co-construction of knowledge; and thirdly, I reflect on the issue of interpretation in relation the integration of the elements of feminist epistemology and Gadamerian philosophy.

WOMEN'S EXPERIENCES

Feminist critiques of traditional research have focused on the dominance of patriarchal epistemology; the emphasis on the objective and scientific and the production of knowledge in which women's voices have been absent. The notion of 'authorised knowledge' as authentic knowledge appeals to the idea of a single reality and universal truth; the claim of objectivity and the production of value-neutral knowledge is valued as opposed to that of 'experiential knowledge' that is considered to be value-laden. Letherby (2003: 24) drawing on the work of Smith (1989) proposes that:

Women's experiences and concerns were not seen as authentic but as subjective, whereas men's were seen as the basis for the production of true knowledge

As a means of legitimising women's experiential knowledge, Feminist Standpoint Theorists embrace the contribution of feminist epistemology as a 'successor science,' which privileges feminine qualities as 'a holistic, integrated, connected knowledge - as opposed to the analytically-oriented and masculine form of knowledge' (Millen 1997:7.2). Whilst this point supports the 'feminine conception of knowledge,' it is considered by some as a 'replacement theory' (Millen 1997:7.3). Whilst the political nature of Feminist Standpoint Theory has raised the profile of women's oppression within the boundaries of patriarchal society, there are at least two theoretical issues that need to be addressed in relation to this thesis.

Firstly, the binary positioning in relation to the use of the category woman as a unitary group; Millen (1997) suggests that by using this reference to women as a unitary group, Feminist Standpoint Theory has achieved the political position of underpinning methodology based on the 'incorporation of experience with a valid alternative epistemology' (Millen 1997:7.4). In so doing, it recognizes women's experience of oppression in the same way; however FST has been criticised for promoting an essentialist category of 'woman' as introduced earlier. I challenge the feminist standpoint suggestion that there is a unitary basis of identity and experience shared by all women. Within this research I privilege the experience of a number of women within a given context and in relation to their positioning to each other. One of the criticisms of standpoint theory claims to knowledge is that it excludes the experiences of different groups of women; for example, lesbians (Rich 1980) or black women (Hill Collins 1997). The 'white heterosexual ethnocentric' focus of standpoint theory was criticized for not representing different experiences of women and considered women's experiences of

oppression in the same way regardless of their social positioning. It is argued that by challenging the use of the category woman in the context of experience, the focus turns from the discussion of oppression to that of difference; in this case women's experiences can be viewed as multiple standpoints developed as a result of a relational process. To argue that all women experience the world in exactly the same way would not acknowledge the differences between women and the oppression that occurs within women's experiences. Letherby (2003:57) concludes:

Differences do exist between women, so the category 'woman' needs to be carefully defined in order to focus on ontological separations as well as similarities. There is a common material reality that all women share which is characterized by inequality, exploitation and oppression, but women are not all oppressed in the same way. It is therefore important to recognize that while oppression is common, the forms it takes are conditioned by race, age, sexuality and other structural, historical and geographical differences between women.

Historical accounts of the development of feminism have noted the empowering and emancipatory nature of feminist thinking, highlighting women's oppression within society and the domination of male epistemology within social policy and practice (Kaufmann 2004). Whilst the focus of patriarchal oppression in terms of discrimination and victimisation has to an extent resulted in a backlash against feminism (Oakley and Mitchell 1997; McRobbie 2008), I acknowledge that the issue of oppression is evident within the policies and practices of reproduction (Walby 1990; Murphy-Lawless 1998; Gould 2002). While the focus of this thesis is not specifically on patriarchy it must be remembered that both midwives and mothers (who are the focus of this research), are situated within the traditional patriarchal system of the maternity services and some may argue that they remain oppressed as a result. FST acknowledges that through the experience of oppression, women are able to understand their experiences of the world around them and as Millen concludes 'it gives them access to a wider conception of truth via the insight into the oppressor' (Millen 1997:7.2). Although this position suggests that women's knowledge is validated in the context of women's oppressed position, it does however neglect the fact that not all women are oppressed or experience oppression in the same way, whilst others may not recognise that they are oppressed.

Secondly, the issue of binary positioning of knowledge and knowledge production; the emphasis on the development of a feminist epistemology as a 'successor science' is considered to promote the binary positioning of knowledge and knowledge production, to an extent that it may limit the development of alternative epistemological positions

between and along gender categories. Moreover, the acceptance of this binary positioning may promote the ongoing discrimination against women who seek careers in traditional male occupations where sexist thinking may exist; men are considered to be the scientists and women are caring and feeling (Powell, Bagilhole and Dainty 2009). Equally it may limit the opportunities for men to work in 'traditionally 'female environments'. An acceptance of a feminist epistemology which privileges the experience of women, supports the point that knowledge is produced by gender alone; knowledge of the world can be based on the interaction between demographic factors including gender, social class and others. From a feminist post-modern position, knowledge is produced in relation to the social positioning and interaction of factors not as a direct result of gender alone. Of course this is not to say that in some cases gender is a more dominant factor.

By promoting male and female ways of knowing, there is a risk that Feminist Standpoint Theory may support the 'masculinist myth of feminine intuition and subjectivity' (Letherby 2003:46), that further promotes the essentialist claims that female knowing is 'invalid, subjective and irrational, as unworthy of inclusion and as opposite to the masculinist ideas about valid knowing' (Millen 1997: 7.4), such resulting in dominant male epistemology. However, the work of Belenky et al., (1997) and Gillian (1993) celebrates this traditional position by suggesting a female way of knowing which values feminine characteristics of empathy, caring and intuition; however these may not be as explicit or common place within a female dominated profession such as midwifery or within midwifery care provided in hospital environments as discussed in Chapter 1.

Whilst this may perpetuate the historical notion that women have not been accepted as legitimate knowers, midwifery writers have celebrated the uniqueness of knowledge around birth, where midwifery epistemology acknowledges 'multiple sources of knowledge gained through personal experience' (Thompson 2004). Although a few researchers have explored midwifery knowledge in relation to intuition, personal experience and contextual knowing (Davis-Floyd and Davis 1997; Kennedy 2000), midwifery remains within the medical patriarchal system, where medical knowledge remains influential. In addition writers and researchers have been reluctant to ascribe a gender label to the 'category of midwife' in relation to the discussions of midwifery epistemology, acknowledging that whilst the majority of midwives are female, a small

number of men are midwives. To develop the discussion further in relation to knowledge production, it is important to acknowledge the contribution of reflexivity within the application of auto/biographical approach and the co-construction of knowledge. The following discussion will consider reflexivity in terms of the significance of my situated position within this research.

REFLEXIVITY

Feminist discussions of reflexivity have focused primarily on the relationship between the researcher and the respondent, where the emphasis has been placed on power relations (Ramazanoğlu and Holland 2002); however others have considered reflexivity in relation to the theory construction and the development of epistemology (Harding 1992).

The emphasis on experience and biography in the context of research has been challenged for generating 'sensational journalism' (Rothman 1986:53). Recognising 'self' is important in relation to both intersubjective and introsubjective reflexivity, to co-construct knowledge and understanding of the issues with respondents, without becoming too self-indulgent. By outlining my biography I illustrate the position and contribution of my embodied experiences within the research. Therefore, by acknowledging reflexivity in this way, it is important to consider that it is an integral part of an auto/biographical approach. Reflexivity is therefore central within my research. Ramazanoğlu and Holland (2002:118) offer a definition:

Reflexivity generally means attempting to make explicit the power relations and the exercise of power in the research process. It covers varying attempts to unpack what knowledge is contingent upon, how the researcher is socially situated, and how the research agenda/process has been constituted. The distinctive feminist interrelation of politics and epistemology means that, despite differences in feminist approaches to knowledge production, the identification of power relations in the research process is generally seen as necessary.

By acknowledging the concept of reflexivity, the researcher has an opportunity to challenge the 'conventional ideals of science, which prefers professional distance and objectivity, over engagement and subjectivity' (Finlay and Gough 2003:1). To counter claims that auto/biographical research is unacademic, generating 'self-indulgent and sloppy intellectual work' (Letherby 2002:143), I would argue that the significant aspect of adopting an auto/biographical approach is the acceptance of the principle of reflexivity where the situatedness of the researcher is considered in relation to that of the respondent. Gray (2008:936) suggests that reflexivity in a research context is defined as

'the researcher's engagements with her own positioning in relation to the world she is researching.'

This is especially true in terms of how my embodied experience of breastfeeding enables me to accept that breastfeeding is not easy and can be fraught with difficulty both for midwives (Battersby 2002; 2006) and mothers (Baxter 2006). I had struggled to breastfeed and had stopped when my son Thomas was two weeks old. As a big baby he required a lot of feeding. I had experienced excruciating breast pain every time I fed him. My nipples had been bleeding on and off for a week and when I eventually spoke to the midwife, I felt that I could no longer continue – breastfeeding had become a punishment. I was exhausted. I felt destroyed by the experience. I rationalised the experience in relation to the association between an emergency caesarean, physical exhaustion and poor lactation. I felt so guilty that as a midwife I was unable to succeed at something which was considered to be so natural and something that as midwives we encourage all mothers to undertake. This feeling of inadequacy made me feel ashamed to be a midwife and a useless mother. I felt that I should be a role model for other mothers but I felt that they were showing me that with all my knowledge and experience I was still subject to the same problems and difficulties that other mothers experience. I thought that I could rely on my knowledge and skills to succeed and really be a 'role model mother' because of my experience. Therefore in this context the question of 'who is the knower in the research relationship?' is rather more complex. Whilst as researchers, we may not be superior to the respondents in terms of embodied experiences; our positioning facilitates the use of our intellectual and personal biographies (Letherby 2003), which enables the final interpretation of data. To develop the discussion further, I use the work of Wilkinson to structure the discussion of reflexivity within a feminist theoretical framework. Wilkinson (1988) proposes three distinct interrelated forms of reflexivity: personal, functional and disciplinary.

The personal dimension of research is seen as enriching and informative. Here Wilkinson (1988) considers issues of identity in which researchers often explore issues that are of personal concern and highlight the auto/biographical approach. The process of writing about my experiences has enabled me to analyse my own positioning as a woman, mother, midwife and academic researcher, in relation to reproduction and childbearing. One of the key issues within this auto/biographical process is the realisation that issues

around identity have been significant within my experience. Since my professional identity has become a dominant identity over the last twenty years as my career has become more established due to the level of accountability, I experienced situations of conflict between my professional identity and my emerging identity as a mother during my experience of pregnancy and birth. In the following discussion I focus on two experiences, which illustrate the conflict and tension between these two identities. The first experience centres on my role as a prenatal screening midwife and illustrates the complexity of working as a pregnant midwife within a highly emotional and often distressing environment; the second focuses on my attendance at a parenthood class.

The role of the prenatal screening midwife involves the co-ordination of prenatal screening tests for Down's syndrome, which included counselling couples for the test and those with high-risk results, together with involvement in amniocentesis procedures. This role also involves being called to the ultrasound department to speak to couples when 'suspicious findings' are found on the ultrasound scan. During my pregnancy I was faced by a number of visits where fetal abnormalities were suspected and referral for further investigations was necessary. Although my pregnancy was visible from an early gestation due to my short stature and large baby, none of the couples I saw as a prenatal screening midwife, questioned either my involvement in their care, or whether I had had serum screening or an amniocentesis myself. I felt guilty at times because as a pregnant midwife I was in the privileged position of power, where I had the knowledge and skills to doubt the normality of their baby. I was part of that process which raised their anxieties in relation to the health of their baby by informing them of a high-risk result or shattered their illusions of the scan picture by referring them for a further detailed ultrasound scan because of suspicious findings. Whilst working in that role, abnormality is commonplace and the couples had little idea that I too shared their anxieties about the normality of my baby. My colleagues were very supportive of me and were aware of the potential emotional difficulties of providing support for women and their partners. These colleagues were also my caregivers and wanted to limit the potential emotional distress for me. They decided that if any positive diagnoses of Down's syndrome were confirmed by amniocentesis, that I was not to visit or counsel the couples or be involved in any termination procedures. Before my pregnancy, I had been involved in the care and support of women who had decided for reasons of fetal abnormality, to terminate their pregnancies and therefore I was well aware of the emotional aspects involved in

providing support and care for couples in this situation. I felt able to continue with this aspect of the role during my early pregnancy, as I felt that I could separate my pregnancy from theirs. However, as the weeks on by, I become more aware of the potential effect of my pregnant body on the individual women. I wondered whether my visible pregnancy caused some distress to the women that I met during that time. Yet many of the mothers thanked me for my support and on occasions suggested that it must be difficult for me to work in such an area as a pregnant woman.

I had looked forward to attending the 'labour talk' with my husband who knew nothing about pregnancy and babies, and left all the decisions to me as I was in the business. When the evening came along, the session was to be held at the local health centre. I was met by the health visitor from the neighbouring county, who informed me that the midwife from the local hospital (the one which I worked at), was unable to attend. She knew I was a midwife there and asked me whether I would answer any questions about the local maternity hospital. Mothers from the area were given the choice of whether to attend the local maternity hospital, which was 4 miles away, or the neighbouring hospital, which was 15 miles away. During the session nearly all the couples attending had planned to birth their babies in the local hospital; I was bombarded by questions.

On reflection, I felt that I had not been given the opportunity to assume anonymity; to sit and enjoy the session as a pregnant woman accompanied by her husband. Whilst I was pleased to help and fulfil my professional obligations I was on maternity leave - this was my special time. I considered that my feelings may be similar to the experiences of mothers who are denied the time to prepare for birth when they experience a premature delivery. I was unsure of the effect of this experience on my husband; after all I felt as if we could have had the conversation at home. I felt as if I had been robbed of the opportunity of being a 'mother in waiting' and I was never to escape my identity as a midwife. My identity as a midwife had become secondary to my identity of being a pregnant woman. I looked forward to the experience of being a mother and saw this time as preparation for that. I thought this session would have been a good opportunity to meet new people as I was new to the area and had worked full time for much of that time. Now I felt as if I had publicly announced who I was and that I was placing myself on the pedestal 'Look at me I'm a midwife – yes, we have babies too.' I wanted to hide who I was – I was not embarrassed to be a midwife as I had always loved the work but I felt that

in this environment I was perceived to be different as I assumed a specific role with expert knowledge. As I was new to the area I saw this opportunity as one in which I could start to develop relationships with other mothers within the area. And I did not want my status as a midwife to exclude me from socialising with others mothers who may presume that I know it all. I knew that having expert knowledge may be useful in terms of discussing issues with colleagues and in making decisions, but as the pregnancy progressed I was becoming more aware of possible clinical scenarios and outcomes associated with my short stature and big baby. Moreover, I knew of course that when I went into labour I would have to experience it like every other woman.

Researchers often explore issues that have some direct relevance to their own biographies, and as such has personal as well as public relevance (Ribbens 1998; Letherby and Williams 1999; Miller 2005). Wilkinson (1988:494) notes:

Within a positivist epistemology, with its emphasis on objectivity, such values are considered sources of bias and obstacles to determining “the facts,” but within an alternative epistemology, which emphasises the social construction of multiple realities and takes reflexivity seriously, they may be seen both as central to and as a resource which informs one’s research. Indeed, such an epistemology may be seen as an essential part of a feminist research paradigm, which emphasises the centrality of personal experience:

However, it is also important to consider here that the emphasis on the personal within research is not exclusively related to feminist researchers alone, as the use of embodied experiences are significant within other academic areas such as disability research (Oliver and Barnes 1997).

Finlay and Gough (2003) suggest reflexivity as intersubjectivity, which has relevance here as an alternative paradigmatic approach to the objective detached role of the researcher within the positivist paradigm. The emphasis is placed on the researcher’s ability to acknowledge their position with the respondent within the research relationship. In this context, this definition centres on researchers’ ability to explore the mutual meanings involved within the research relationship, based on personal biographies. Moreover, it highlights a process where the researcher aims to consider the self in relation to others. This highlights the relationship between intersubjectivity and empathy within a reflexive approach. Finlay (2005:272) suggests that ‘empathy is not just about emotional knowing, it is a felt, embodied, intersubjective experience. It is also an experience that underpins researchers’ ability to understand their participants.’ Central to this process is the

capacity and willingness to empathise with the respondent and to demonstrate empathetic listening. As a key component of feminist research, empathy is a relational aspect of the reflexive embodied nature of the relationship between the researcher and the respondent.

Likewise, reflexivity is viewed as introspective, a means by which the researcher can 'look within'. England (1994:82) writes:

...reflexivity is self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher. Indeed reflexivity is critical to the conduct of fieldwork; it induces self-discovery and can lead to insights and new hypotheses about the research questions. A more reflexive and flexible approach to fieldwork allows the researcher to be more open to any challenges to their theoretical position that fieldwork almost inevitably raises.

The process of introspective reflexivity enables the researcher to acknowledge by adopting an auto/biographical position, the emotional concerns and reactions experienced during the research process. Self-reflection can be a useful tool to provide data on the researcher's emotional journey through the research process. By completing a reflexive diary, the researcher can identify and examine the issues that arise. Documenting personal data in this way can support the conduct of the research and analysis of the data and illustrate the impact of emotion within research. However in spite of this, it is important to avoid the prominent nature of the researcher's voice in the research as this may limit the opportunity for the respondent to engage in the conversation.

Secondly, the concept of 'functional reflexivity' considers the role of the researcher in relation to the research, and considers the power relationships between them. In this context reflexivity is primarily concerned with the methodological aspects of gaining good quality data. Wilkinson (1988:495) writes:

...in taking reflexivity seriously, one is obliged to acknowledge the continuity between the psychological processes of researcher and researched, and to accept that they are necessarily engaged as participants in the same enterprise – a dialogue of knowledge–construction

The researcher is not only considered part of the research process - 'a research tool' but an equal participant. Chesney (2000) suggests that through reflexivity there is an auto/biographical connection between the researcher and the respondent. The researcher occupies an 'insider' rather than an 'outsider' position. Feminist research

through reflexivity challenges the issue of power and the distribution of power within the research relationship, and suggests a reciprocal relationship in which a partnership approach of mutual empowerment exists. Working collaboratively with the respondents is by no means a process of paying lip service to the notion of reciprocity. Moreover, it could be argued that as Ramazonoğlu and Holland (2002:118), suggest 'reflexivity is a principle of good feminist research', it is an attempt to uncover the power relationships and make them explicit. Whilst much has been written about the researcher-respondent relationship in qualitative literature (Gubrium and Holstein 1995; Holloway and Wheeler 2002; Mason 2002), some authors have also pursued the notion of achieving reciprocity within a reflexive process as a principle of good feminist research practice, in which data generated can be more meaningful (Oakley 1981b; Finch 1984). Oakley (1981b) talks about the importance of reciprocity as a means of generating what she calls 'intimacy' within the interview situation. Intimacy in this context is considered as the level and depth of rapport between researcher and respondent, based on a relationship of empathy and mutual respect. This interactive process within the feminist paradigm is one of mutual collaboration and empowerment. However, researchers have challenged this by describing the idea of an equal research relationship as an 'illusion' (Millen 1997). Kelly, Burton and Regan (1994:37) also add:

...It is we who have the time, resources and skills to conduct methodical work, to make sense of experience and locate individuals in historic and social contexts ... it is an illusion to think that, in anything short of a participatory research project, participants can have anything approaching 'equal' knowledge to the researcher

I suggest that this process is not as straightforward since a fully reciprocal relationship may not be achievable in relation to the power relations within the researcher-respondent relationship. This reflects the second point; the issue of positionality. Positionality defined as the position of the researcher in relation to the research, is a crucial concept in relation to achieving a reflexive process within the auto/biographical approach (Reay 1996). Many feminist researchers acknowledge that 'women researchers often choose topics which mean something to them' (Letherby 2000:94).

I argue here that by privileging the position and experience of the researcher through the use of their biography, their experience may be considered as the norm against which other experiences are judged. The researcher must guard against replacing the voice of the respondents with their own voice. It is also reasonable to suggest here that if the researcher is over familiar with a particular subject or experience, she may by the virtue

of her own biography become 'de-sensitised' to the experiences of respondents (Greed 1990), which raises questions of interpretation and representation of women's experiences and the value of the knowledge produced. Furthermore, Letherby (2003:140) refers to the notion of 'intellectual privilege,' as a concept that ultimately accepts that the researcher, by virtue of their knowledge and training, holds the balance of power. The researcher maintains control over the research material and following the interview leaves the location armed with the respondent's words; ultimately the power lies with the researcher. Recognising the researcher's power in this context is an important aspect of auto/biographical work where the researcher can explain their positioning.

As a way of addressing the issue of potential 'bias', it is important here to consider the ongoing debate within the feminist literature, regarding the degree to which objectivity should be recognized within feminist qualitative research. Some researchers would say that 'bias' is inevitable within research, and that the aims should be 'to make bias visible' (Letherby 2003:71). Whilst some feminists argue that objectivity is neither desirable or achievable, others would argue that to reject the notion of objectivity would actually promote the system of exclusion and leave the production of rational thought to men alone (Jayaratne and Stewart 1991). Feminist Standpoint Theorists, however, focus on the development of knowledge which is grounded on the experience of women and reject the concept of objectivity as a male construct. They accept the fact that the use of reflexivity can result in 'strong objectivity,' and the development of research, which is scientifically preferable (Stanley and Wise 1993). Harding (1993) calls for 'strong objectivity' and considers a degree of objectivity as key to establish the validity and authority of feminist knowledge. Alternatively, Letherby (2003) puts forward the notion of 'theorized subjectivity' as an alternative to objectivity and makes the point that by acknowledging the subjectivity of the researcher, the research produced is more objective, since it is value-explicit. Letherby (2003:3.4) writes:

...what I refer to as 'theorised subjectivity', which I do not believe is predicated upon an objectivity/subjectivity binary position. Rather it relies on recognition that, while there is a 'reality' 'out there', the political complexities of subjectivities and their inevitable involvement in the research/theorising processes, make a definitive/final statement at best wishful thinking, in practice impossible. In other words, we need to accept that objectivity in social research is never possible, but what is possible, desirable and necessary is the theorization of the subjective (including the researcher's motivation and practice and the respondent's expectations and behaviour. This approach, I believe, highlights the dynamic relationship between the process and the product of research and the links between research in theory and practice.

Thirdly, Wilkinson's notion of 'disciplinary reflexivity', has political relevance to theory development and epistemology, since she states that it is 'the requirement for a discipline or sub-discipline to explain its own form and influence...' (Wilkinson 1988:495). I maintain here that disciplinary reflexivity considers knowledge production in terms of not only 'knowledge what but also as knowledge for' (Stanley 1990:15) and in this way 'reflexivity has become much more than methodological self-visibility' (Kingdon 2005). This broad approach encompasses the process of both personal and functional reflexivity as essential aspects in assessing the impact of the research. In this context it is an ethical responsibility; the researcher must question the position of the research in terms of its contribution to the development of theory within the profession or discipline and also how it contributes to existing theory within that field. I draw on the work of Letherby (2003:3.3) to support my position here:

I acknowledge the inevitable political connotations of theorizing and I believe that one way to challenge traditional approaches is to make the political aspects of researching, writing and theorizing explicit and accessible

Furthermore, in accepting that disciplinary reflexivity is a political approach, the issue of the researcher's interpretation of the data becomes important in relation to the representation of women's accounts and as a means of producing accountable knowledge. This is clearly relevant in the application of auto/biography and to the discussion of the methodologies. For these reasons the contribution of auto/biography will be considered in more detail.

THE CONTRIBUTION OF AUTO/BIOGRAPHY

At the beginning of this chapter I outlined that by adopting a reflexive auto/biographical position, I privilege aspects of my own biography as the basis this research. By detailing some of my embodied experiences of pregnancy, childbirth and motherhood I make explicit my position as researcher in relation to the focus of the research. As a result the contribution of auto/biography to my research is considered in terms of firstly enhancing my relationship with the respondents, and secondly the legitimacy of the research.

Whilst I consider in more detail in the next Chapter the practical experiences of interviewing midwives and mothers within my research and therefore illuminate 'auto/biographical practices', the theoretical discussion of positionality and reflexivity earlier in this chapter is key to understanding the complexity of the relationship between the researcher and the respondent. Supporting the theoretical and methodological

discussion of positionality and reflexivity with the researcher's embodied experiences enhances the depth of the research and the relationship between the researcher and respondent. For this reason, the impact of the research relationship on the co-construction of knowledge is made more explicit within an auto/biographical approach. The dynamics of the research relationship however, is not always apparent in research and therefore by using auto/biography, I am drawn to acknowledge the issues of positionality and reflexivity, and also to illuminate them further for the reader. This relationship is not restricted to the interview alone, but continues throughout the analysis and representation of respondent voices within the writing of the research.

Secondly, within my biography I have drawn on my most relevant experiences to underpin and support the focus of this research, and as a means to develop a more nuanced understanding of the experiences of midwives and mothers. Whilst my embodied experiences have shaped the focus of this research and the design and conduct of it in terms of addressing the aims of the study, acknowledging my biography by the use of the auto/biographical 'I' enhances the authenticity and credibility of the data generated by making the role and contribution of the researcher explicit. Furthermore, I argue that this approach enhances the co-construction of accountable knowledge as discussed earlier in this chapter, since the researcher's biography is an explicit expression of their experience and their position in relation to the research.

To summarise the discussion thus far, I have considered that the theoretical framework underpinning this thesis honours women's experiences as a legitimate source of knowledge. From this position I have considered some of the debates regarding Feminist Standpoint Theory and conclude that the binary positioning of women as a unitary group has implications for the representation of difference within women's experiences and for the development and production of feminist knowledge. Drawing from this discussion, it is also reasonable to conclude that knowledge is produced in relation to social positioning rather than gender alone. Furthermore, I have discussed some of the challenges to adopting an auto/biographical approach and conclude that the situatedness of the researcher and the application of reflexive practice are significant to the co-production of accountable knowledge. However, in an attempt to explore women's experiences it is important to consider the contribution of phenomenology as an interpretive research approach within this research, since it directly addresses 'being in the world' and the

perceptions of those being researched to whom it gives a voice. The next section explores this aspect in more detail and presents the justification for the use of an interpretive research approach guided by Gadamerian hermeneutic philosophy.

PHENOMENOLOGY

Great confusion exists around phenomenology, since it is both a philosophy and a method (Oiler 1982; Wilkes 1991), and is variously defined in relation to the schools of phenomenological philosophy; transcendental phenomenology, existential phenomenology and hermeneutical phenomenology. In general phenomenology describes a range of positions from which the study of lived experience can take place. Hermeneutic phenomenology is concerned with the interpretation of human experience as it is lived. The focus is placed on exploring aspects of day-to-day life with the aim of constructing meaning and gaining understanding of what it means to be that person (Walters 1994).

The intersection between the disciplines of midwifery and sociology as illustrated within this thesis, highlights the appropriateness and relevance of hermeneutic phenomenology within the wider feminist context as a means of exploring women's experiences of reproduction. The use of phenomenological interpretation of experience is not new to feminist research; the work of de Beauvoir (1953) is considered to be the most influential in feminist phenomenology due to her focus on embodied lived experience. Since the publication of the influential work of Young (1990) and others (Smith 1987; Levesque-Lopman 1988; Grosz 1994), it is noteworthy that phenomenology has been used in different ways appealing to different philosophical work; for example Levesque-Lopman (1988) used Schultz's phenomenological sociology in the study of women's subjective bodily experiences; whilst Grosz (1994) drew on the work of Merleau-Ponty (1962) to develop corporeal phenomenology in her study of the body. However, whilst it is clear that the relationship between phenomenology and feminism has created ambivalence in relation to the relevance of different philosophical work to feminist theorising, Fisher (2000:33) argues with reference to previous phenomenological work (Levesque-Lopman 1988), that the interaction between feminism and phenomenology may take different forms. She argues that:

Phenomenology and feminism share this commitment to descriptive and experiential analysis, where the systematic examination and articulation of the nature of lived experience, along with the attendant theoretical and practical implications, functions as

the basis for reflective discourse. Indeed, in a fundamental sense the cornerstone of feminist theory and politics is the elaboration and analysis of the particular situation and experience of being a woman.

More importantly, Fisher (2000:33) considers phenomenology as 'a philosophy of experience' that offers feminism:

...an articulated framework for experiential accounts as well as a mode of expression for the issues of sexual difference and specificity that lie at the core of feminism (Fisher 2000:34).

She proposes that the development of a specific feminist phenomenology along the lines of what Gadamer describes as 'fusion of horizons.' I aim to demonstrate that the work of Gadamer, although rather more complex and considered problematic by some feminists, is suitable within a framework which adopts an auto/biographical approach. Moreover the philosophical writings of Gadamer appear to have been adopted by midwifery academics over the last few years, illustrating the relevance and appreciation of his work in this context. It is clear that Gadamer's philosophical writings offer an appropriate basis from which to explore midwives' and mothers' reproductive experiences, however, whilst some midwifery researchers have discussed how Gadamerian philosophy has influenced their research (Mander and Melender 2007), others offer little detail (Wahn, von Post and Nissen 2007). I suggest here that as a result of the lack of engagement with philosophical concepts, novice researchers within the academic discipline of midwifery fail to take the opportunity to appreciate fully the diversity within different orientations of phenomenology. As a result, the research may be limited in terms of its philosophical relevance and the resultant knowledge generated could be incomplete. Instead of developing and enhancing philosophical knowledge relevant to the exploration of women's experiences, novice researchers may consider the whole process as complex and unwieldy.

FEMINIST EPISTEMOLOGY AND GADAMERIAN PHILOSOPHY

As previously discussed, the interpretation of data is important to the representation of women's voices within feminist research. The process of interpretation however, can be problematic if the position and status of the researcher is unknown, where questions of motive arise. Furthermore the representation of women's account should reflect the researcher's attempt to draw on both her position and the position of the respondent to find mutual understanding. This is the central theoretical aspect of the research on which

this thesis is based; by acknowledging my own biography I clearly state my position in relation to the research. For this reason I have drawn on the philosophy of Hans Georg Gadamer to support my position. The following discussion offers some insights into the philosophical thinking of Gadamer, which underpins the methodology detailed in Chapter 3.

Whilst phenomenology therefore offers the opportunity for researchers to explore the 'lived experiences' of people in specific circumstances, Gadamer's work is more ontological in nature, where the nature of 'Being' can be understood through the interpretation of language. In his most renowned work on 'philosophical hermeneutics' (Gadamer 2003), he sets out a vision in which the way human beings understand and live in the world can best be characterized as a process of constant interpretation. Hermeneutics has historically been associated with the interpretation of biblical texts, and is widely defined as the art of understanding through interpretation. Three central and interrelated principles are relevant to this research in relation to the development of understanding and interpretation.

Firstly, Gadamer (2003) rejected the idea that experience or *Erfahrung* could be explored from the position of a neutral observer, detached from the respondent and the nature of the experiences. He proposed that historical awareness or consciousness was a condition to the development of knowledge and understanding, in which it was important to recognise personal history and positioning. Furthermore he believed that the recognition of preunderstandings or prejudice was a condition to understanding or *Verstehen*. Here he emphasises the importance of being situated in the world before understanding can take place. Fleming, Gaidys and Robb (2003:115) clarify this point:

It is not possible to lose one's preunderstandings as everyone always has a preunderstanding of the topic in question. Although researchers in the natural sciences see this as negative and make significant efforts within their selected methods to control their preunderstandings, Gadamer (1990) considered it is only through one's preunderstandings that understanding is possible. If one does not recognise one's preunderstandings, there is a risk that one will fail to understand or will misjudge meaning.

Gadamer's concept of preunderstanding, reflects the importance of the researcher's ability to identify their preunderstandings and he points to the fact that researchers should work out their 'forestructures' in terms of the things themselves and by writing stories (Fleming, Gaidys and Robb 2003). Whilst Wall et al., (2004) consider the use of a

reflective diary to develop bracketing skills in which existing biases can be identified and kept separate from the research; I would argue that the reflective diary is an essential tool in which preunderstandings can be documented and used to inform the research. A reflective diary therefore enhances the process of descriptive reflexivity and contributes to a process of analytical reflexivity which enables the researcher to examine the meaning of their reflections and experiences in the context of the research (Letherby 2002). Gadamer described the respondent as a co-researcher, in which the researcher is an active participant. Fleming, Gaidys and Robb (2003:117) write:

Understanding will appear through the fusion of the horizons of the participant and researcher. Horizon is the field of vision, which includes and comprises everything that can be seen from one perspective (Gadamer 1990). However, as the horizon of the present is in the continuous development, understanding of the participants and researcher will merge into a new understanding. During the research therefore, the researcher should thus attempt to understand how personal feelings and experiences affect the research, and then integrate this understanding into the study.

Identifying preunderstanding may not be easy for a researcher and demands that a reflexive approach is utilised to understand themselves before embarking on understanding others. In my research, adopting an auto/biographical approach has enabled me to examine my own 'historical consciousness' and through my reflection on my experiences of reproduction and childbirth I have been able to examine my preunderstandings. Indeed as the research progresses, preunderstandings may be challenged and may change as a result. However, the important point here is to recognise how these preunderstandings influence the research and more importantly how they may influence the interpretation of respondent's data.

Secondly the process of identifying preunderstandings highlights the notion of *Bildung* or openness to understanding. Turner (2003:6) describes this as 'keeping one's self open to what is other and embracing more universal points of view: or detaching one's self from one's immediate desires and purposes'. It is important to consider that despite identifying preunderstandings, researchers are required to examine bias within their thinking. An awareness of bias may be challenged through a process of in-depth interviewing and analysis. To illustrate this point I draw on the work of Turner (2003:12) who writes:

...one bias that I carried into my study was a belief that some participants would probably be without hope, that is they would be hopeless. This believe, however, was challenged as I attentively listened to their stories. I realised that although there were times in their lives when they expressed that they felt bleak, they did not define these moments as hopelessness, and further said it would be impossible to live without hope.

Their revelations caused me to redefine my concepts of hope and hopelessness, coming to the conclusion that the opposite to hope is not hopelessness, but despair. With these thoughts in mind, it can be seen that when constructing a study using Gadamerian phenomenology, there is an imperative to present information to the reader regarding our own understanding and unveil our own prejudice, so that our readers can determine for themselves whether there is any truth-value to our findings.

Thirdly, Gadamer considers the researcher's horizon or perspective, (which I consider here to develop from my biography) as a wide vision which the researcher must have in order to understand. Gadamer (2003: 302) defines horizon as:

Every finite presentation has its limitations. We define the concept of "situation" by saying that it represents a standpoint that limits the possibility of vision. Hence an essential part of the concept of situation is the concept of "*Horizon*." The horizon is the range of vision that includes everything that can be seen from a particular vantage point...A person who has no horizon is a man who does not see far enough and hence overvalues what is nearest to him. On the other hand, "to have an horizon" means not being limited to what is nearby, but being able to see beyond it. A person who has an horizon knows the relative significance of everything within this horizon, whether it be near or far, great or small. Similarly, working out the hermeneutical situation means the achievement of the right horizon of enquiry for the questions evoked by the encounter with tradition.

Within this process of understanding, he proposed the notion of a 'fusion of horizons' described by Pascoe (1996:112) as a process in which 'understanding ...occurs when the horizon of the scholar, intersects or fuses with the horizon, context or standpoint of the object under inquiry'. Recognising preunderstandings is also central to the development of a horizon. In an attempt to achieve this fusion, the horizon of the respondent is also required and is best achieved through the use of 'open and participatory dialogue' (Pascoe 1996: 112). The use of the interview therefore is a key method in which to satisfy Gadamer's principle.

FEMINIST CRITIQUES OF GADAMER

The discussion thus far has considered the relevance of Gadamerian philosophy within this thesis. However, as this research is established upon a feminist theoretical framework, it is important to consider the fact that Gadamer like so many other philosophers has been examined and interpreted by feminist scholars. Although a detailed discussion of all the feminist debates concerning hermeneutic phenomenology is beyond the remit of this thesis, it is nevertheless important to accept that Gadamer's work has attracted much attention from feminist theorists. It is noteworthy that within Code's (2003) edited collection of essays on the interpretation of Gadamer's work, eleven

out of the fifteen essays find Gadamer's work a useful resource for feminist theorising. Code (2003:4) summarises as follows:

Gadamerian hermeneutics – in which knowing is engaged, situated, dialogic, and historically conscious – has much to offer to feminists and other theorists of subjectivity, agency, history and knowledge who are disillusioned with the empiricist-positivist legacy that manifests itself in epistemologies of mastery and domination, with an operative conception of objectivity that requires dislocated, interchangeable knowers who stand as distant, disinterested spectators of the objects of knowledge.

One aspect that is of relevance to this thesis is the apparent absence of any discussion of gender within his work. The implication of this absence, is suggested by some to be symptomatic of masculinist philosophy; Gadamer's work is rooted in patriarchal authority of Western philosophy, which as Tuana (2003:viii) suggests is the concern of 'upper-class white males.' Other feminist theorists (Schott 1991; Elam 1991) have considered Gadamer's work to be 'conservative and patriarchal in that it celebrates custom and tradition, reifies the past and assigns a privileged position to male-biased language' (Hoffman 2003:84). However, against this background Alcoff (2003) identifies four key aspects of Gadamer's philosophy, which she considers as useful to feminism since 'they credit some traditionally feminine characteristics as epistemically valuable' (Alcoff 2003:233); they include 'the openness to alterity (Otherness), the move from knowledge to understanding; holism in justification and immanent realism' (Alcoff 2003:232). Moreover, Hoffman (2003:82) considers that hermeneutics provides a fruitful means of feminist theorizing since Gadamer provides a 'model of understanding.' Within this there is recognition of situatedness and a critical challenge to reductionist universalism. She considers that much of the feminist theorizing that occurred between the 1960's and 1980's was as guilty of promoting false universalism as traditional philosophical theorizing.

From my reading of Gadamer's classic text 'Truth and Method' (Gadamer 2003) and the feminist critiques of his work (Code 2003), I argue that Gadamer's silence on the issue of women, unlike the derogatory discussion of women by other philosophers, is by no means a negative position, as Code (2003:2) clarifies:

it is reasonable to conclude that there is no "woman question" for him; hence variations on and modalities of the second set of question – how to find feminist resources in his philosophy – are more readily available for feminists reading his work.

Indeed I would suggest that the absence of woman from his work suggests an invitation to feminists to engage with his work as seen in the work of Alcoff (2003) and Hoffman (2003). It is also interesting to note that his work also avoids the discussion of power gender and

with politics, and in this context it could be argued that his philosophy is 'politically incompetent' (Code 2003:15).

Another key aspect, which is relevant to this thesis, is the situatedness of the researcher and the position and significance of the other within the process of understanding. Alcott (2003) considers that Gadamer's work offers the opportunity to consider the locatedness of knowers based on the relationship between I-Thou. This raises the issue of the Other within this relationship. Alcott (2003:232) suggests that this is not a process to eliminate the 'I' but to 'develop a creative and coherent fusion with the position of the Other.' However, the position and interplay between the interpreter and respondent within this dialogue and ultimately the issue of understanding, is contentious. In contrast to other discussions within Western philosophy where the nature of the participant and that of the dialogue is restricted and determined, Gadamer suggests that conversation should be elicited with partners everywhere; he suggests that dialogue with those who are different encourage a reassessment of self and the world. However, Fleming (2003:110) warns feminists not to be seduced by Gadamer's engagement with the other since she proposes that 'hermeneutical courting of the other is purely instrumental.' She maintains that in the traditional philosophical thought the interpreter is inevitably male and cannot be female. She takes the position that 'the dialogue partners do not pledge to understand each other, they are not equal, and there is no genuine reciprocity' (Fleming 2003:111). Indeed whilst Fleming appears to come from quite a different position to other theorists, she considers that it is implausible within the principle of 'fusion of horizons' to consider that understanding can be achieved in this way as the Other in this context has no say. In this way Fleming concludes that Gadamer inscribes difference into his discussion of understanding.

Nevertheless, I agree with Hoffman's conclusion (2003) that it would be a misrepresentation of Gadamer to refer to him as a silent feminist, as his work is more about developing people's judgements rather than commenting on social and political issues including gender. In this context Gadamer's philosophical hermeneutics, presents an ideal framework from which feminist theorizing can develop.

CONCLUSION

In this chapter I have detailed the theoretical issues which emerge from the application of an 'auto/biographical' approach and focus on the issues of positionality and reflexivity as

key contributions. I have illustrated the importance of the reflexive engagement of a researcher with the research and the importance of the researcher's biography within a feminist epistemology. Adopting this approach is not straightforward as it requires the researcher to give of themselves within the research; not all researchers will be prepared for this level of personal engagement as it places them in a vulnerable position. However, whilst disclosing the 'self' within a reflexive framework may lead to the exposure of unresolved issues, the use of the researcher's biography enhances the production of knowledge by exposing the position of and challenging the relationship between the researcher and the respondent. For this reason, the focus on the production of accountable knowledge is significant to aims of this research, in terms of exploring midwives and mothers' experiences. This is further enhanced by the use of an interpretive research approach within this research, which gives voice to their experiences. I also considered some of the feminist debates in relation to Gadamer's philosophy and illustrated how the interaction between feminist theorising of auto/biography and Gadamerian philosophy supports the application of a reflexive auto/biographical position.

To enhance the methodological discussion within this thesis, in the next chapter I focus on the methods used to meet the aims of the research and demonstrate how the theoretical concepts discussed in this chapter underpin the conduct and analysis of twenty-seven interviews. Chapter 3 illustrates the aspects of 'auto/biographical practice' in doing research with midwives and mothers and considers some of the challenges of undertaking research using this approach.

CHAPTER 3

DOING RESEARCH WITH MIDWIVES AND MOTHERS

INTRODUCTION

The aim of this chapter is to critically discuss how methods informed by the theoretical concepts discussed in the previous two chapters were used to achieve the aims of the research. I consider the ways in which the conduct of the fieldwork endeavoured to support feminist principles and demonstrate good research practice. Selected excerpts from my fieldwork journal are used to support specific issues and illustrate the reflexive nature of the research.

In Chapter 2, I established the rationale for the application of an auto/biographical approach by drawing on my embodied experiences of pregnancy, childbirth and motherhood, placing that discussion within a feminist theoretical framework. I also considered how the use of an interpretive research approach guided by Gadamerian hermeneutical philosophy supports an auto/biographical approach. I discussed the importance of the concepts of reflexivity, positionality and reciprocity as key feminist principles and their contribution within a phenomenological context to the exploration of women's experiences. Whilst feminist researchers agree that there is no such thing as a feminist method, much feminist research appeals to qualitative methodologies that explore women's experiences. It is important however to consider that as Letherby (2003:81) writes:

... it is not the use of a particular method or methods which characterizes a researcher or a project as feminist, but the way in which the method(s) are *used*.

As outlined in the introduction, the research on which this thesis is based, explores the issues of identity and reproduction in relation to the reproductive experiences of midwives and mothers; therefore the use of an inductive approach is appropriate in which the methods of data collection and data analysis support the theoretical framework adopted. To explore further the 'biographically grounded relationship' (Wilkins 2000:34) between women around reproduction and birth, it is useful to return to the three research aims. The first aim concerned the theoretical and sociological

understanding of gender identity in relation to the reproduction midwifery and motherhood in which the meaning and significance of gendered identity would be examined in relation to how gender operates in midwifery. The second and third aims of my research focus on the experiences of midwives and mothers; the focus on midwives personal experiences of pregnancy and birth and the contribution of the meaning of motherhood from the experiences of both midwives and mothers.

This chapter is divided into three parts. In the first part I focus on the methods used to obtain the study groups of midwives and mothers. Within this, I critically examine the methods used and consider the difficulties experienced during the fieldwork. A discussion of the in-depth interviewing approach used follows in the second part. In the third part I consider the analysis of the interview data and extend the methodological discussion begun in Chapter 2, to support the application of Gadamerian hermeneutical philosophy. This discussion is organised to reflect the sequence in which the research was undertaken and therefore begins with a discussion of the ethical considerations.

ETHICAL CONSIDERATIONS

Initial ethical application and registration was forwarded and approved by the University of Leicester in 2003 where I was originally registered and further approved when registration was transferred to The Open University in 2005. As all the respondents were based within the National Health Service (NHS), Local Medical Research Ethics Committee (LREC) approval was required. All the relevant documentation was completed together with the signature of the Head of Midwifery of the hospital Trust where the respondents either worked or where cared for. In addition to the application document, a copy of the research proposal, letters of information for both study groups and consent forms were included for consideration. Approval was granted in May 2003 following revisions to the original application. These revisions were requested by the Local Medical Research Ethics Committee, in respect of the following points:

1. The committee requested that details of the management of respondents who became distressed during interviews had been omitted. As a result I devised a protocol to satisfy the committee of my commitment to ethical research practice. This included the practice of abandoning the interview if the respondent became distressed, turning off the recording device and utilising previously acquired counselling skills to calm the respondent. Additional support from other health

professionals would be sought if required and the respondent would be advised to call a counsellor. A counsellor was also approached and agreed to be a contact for any of the respondents who required further support following the interview. Her details were clearly printed on the information sheets (Appendix 1, Appendix 2).

2. The committee considered that the Letter of information and Invitation for mothers was too formal. Amendments were made to make the letters more personal (Appendix 2)
3. A separate opt-in form was requested by the committee to enable respondents to express their wish to participate without having to return their consent form (Appendix 3) prior to the interview. A form was devised to meet this request (Appendix 4) and was used on two occasions.
4. A detailed explanation of the underlying theoretical perspective of the study and qualitative analysis method was also requested to support the research proposal. This was completed and submitted as requested.

In accordance with Research Governance (DH 2001) ethical approval was also sought from the Trust Research Governance Committee and therefore all the relevant documentation previously approved by the LREC was submitted and approved by July 2004.

I was eager to demonstrate that the research met all the ethical requirements and that my practice as a researcher was ethical and supported the principles of feminist research. One of my concerns centred on informed consent. Participation was considered voluntary and has been discussed in relation to recruitment. When I arrived at the respondent's home I asked them again about the research and discussed the consent form, which we both signed.

The other concerns centred around the issues of anonymity which centred on protecting the identities of those who participated and confidentiality not only in terms of interviewing but also in terms of the representation of their accounts on paper. I have already stated that two midwives expressed their interest in participating whilst I visited the ward. During this visit I was concerned that their interest and potential participation would not become common knowledge. I wanted to ensure that the information they shared with me would be treated with respect and that I would use my knowledge and expertise to protect their identity in future publications. I had included on the information

sheet my intention to use pseudonyms to protect the identity of individuals. However I could not prevent them from talking to each other about the study. In another situation, a midwife at the end of an interview suggested that a colleague would be interested in participating and that she would now be able to tell her all about it. Whilst it could be argued that this contributes to a snowball effect, there is a danger that close groups of individuals could become involved thus compromising the anonymity and confidentiality of the data once in print.

Working as a lone researcher

As a lone researcher, potential Health and Safety issues were identified before fieldwork commenced (Craig, Corden and Thornton 2000). It is important to consider that working as a lone researcher is similar to working as a midwife within the community as the context of the visit is of a similar focus therefore similar precautions were taken. This may explain the fact that the discussion of safety issues in midwifery research is sparse. Hughes (2004) suggests that the discussion of safety issues is more prominent in social sciences than in health care or nursing research (Lee-Treweek and Linkogle 2000). Safety issues were considered in relation to two specific points; firstly, as respondents were encouraged to choose the location for the interview to ensure that they were comfortable with the interview situation, the majority chose their own homes. Although the nature of the research did not pose any direct threat in comparison to research focusing on other specific groups e.g mental health patients; as the respondents lived across a large geographical area, I was required to drive long distances at times and considered a potential threat to my safety. Physical harm was therefore a primary concern; Arendell (1997) highlights the key gender issue in relation to the risk of sexual assault for women researchers. However, in order to maintain my safety as a researcher, details of the interview location but not the name of the respondent, were made available to recognised personnel at the University prior to each interview (Paterson, Gregory and Thorne 1999). I informed the recognised personnel when the interview had ended and when I had left the location. In addition I carried a mobile telephone. No Health and Safety problems were experienced during the study.

Secondly, it has been recognised that interviewing respondents on personal experiences may cause emotional distress for some and the provision of counselling services had been made available to support respondents as an example of good research practice.

Metaphors such as 'Pandora's box' (Ramos 1989) and 'tin-opener effect' (Etherington 1996) have been used to describe the potential emotional upheaval of research that requires the respondent to discuss their personal experiences. However, the researcher can also be vulnerable (Rager 2005), especially when research involves the recall of extremely distressing experiences or may surface mental health difficulties. Moyle (2002:270) suggests that researchers can feel 'isolated and emotionally overloaded' especially when the respondents are depressed. Researchers can also assume the role as 'secret keepers' (Dickson-Swift, Liamputtong and James 2008), if the respondents disclose information in confidence. This can be a heavy burden for researchers, especially when they hear information about experiences of abuse for example. There may be situations when mothers disclose experiences, which raise issues and which go beyond the interview situation. Anon (2006:229) raises an important issue, which challenges all researchers who conduct research with mothers and children. As a psychologist conducting doctoral research, this researcher illustrates clearly an ethical dilemma in relation to child protection:

One woman in the course of our conversation disclosed graphic verbal and visual representations of how she had imagined inflicting harm upon her children. The woman repeatedly described intense emotions of hatred and rage towards her infants. The methods through which she fantasized exacting harm were brutal, and I perceived them to exceed the unconscious bursts of irrational anger and frustration that mothers' can describe towards their offspring. Although I was shocked by the revelations, I remained as impassive as possible, and the interview progressed until the intended subject area had been exhausted. When the interview concluded I felt unable to leave, duty bound by these disclosures and my ethical responsibilities. As I sat with the mother, I continued to probe her emotional well being and available support networks. The participant, intuiting my concerns, informed me that she was 'not intending to hurt' her children. The woman said that she was able to discuss her feelings with her partner and close friends, and her partner provided respite when these feelings became overpowering.

This example illustrates the fact that some mothers may use the interview situation as a 'confessional' (Lupton 1998:92), in which she may feel comfortable to discuss her difficulties with a non-healthcare professional who she may consider as a person who will listen to her with out making judgements. The researcher as a result may be placed in a difficult and ethically challenging position. Moreover, Lankshear (2000) in an ethnographic study on a maternity unit recounts the way in which the research triggered painful memories of her own childbearing experiences. She illustrates the personal effect of the research:

...at times the process was painful for me, It made me confront and remember things that I preferred to block from my mind...it generated questions but could not give me answers, My view of and feelings about my life and past were threatened, The research was without a doubt dangerous emotionally for me (Lankshear 2000:85).

Personal involvement and engagement in research is not without its risks as described above. However as a researcher with professional and personal knowledge of the subject of the research, I had the advantage of possessing professional knowledge, which could place potentially distressing conversations with respondents in a midwifery or obstetric context. Nevertheless, counselling arrangements were made to enable me to debrief my own experiences as required. The opportunity to meet up with a mentor was also an opportunity to debrief and consider some of the issues raised without breaking the confidentiality of the respondents. On occasions, specific experiences resonated with my own; one such example was that of Kirstie's experience of having her baby admitted with bronchiolitis in the neonatal period which reminded me of when my son was admitted at 5 weeks old with suspected meningitis. Whilst the circumstances were different, I shared her emotional upheaval of seeing her baby undergoing tests and having intravenous equipment inserted into her baby's hand. It reminded me of how I insisted on being present when my son had a lumbar puncture to obtain a sample of the cerebral spinal fluid (CSF) for microscopic examination and culture. The feeling of wanting to observe these investigations as the carer, was counteracted by the feeling of needing to be present as a professional, to satisfy myself that the investigations were performed accurately. The similarity in our emotional response as mothers reassured me that my own response at the time of my son's admission was neither unusual nor exaggerated. This created a specific personal connection with Kirstie, which I was able to use as a platform for the interview. In other interviews where there was no shared emotional experience, other commonalities in professional experience were equally significant in forming a connection. Whilst both midwives and mothers recounted emotionally laden experiences, I felt able to rationalise the experiences I heard in relation to my own experiences as a mother, balanced with the experiences I had had working as a midwife.

SELECTING STUDY GROUPS

The aim of selecting two study groups, one comprising midwives and the other mothers within the immediate postnatal period was to enable the exploration of issues from the perspectives of both a professional and lay groups of women. As discussed in Chapter 2,

the relationship between midwives and mothers is such that in the exploration of any issues around birth the perspectives of both midwives and mothers are important to enable a more comprehensive understanding of the issues. Although reproduction is central to midwives and mothers from a professional, a lay or a combination of perspectives, the focus on both groups was a deliberate attempt to explore how midwives were conceptualized in relation to their relationships with mothers. Restricting the research to midwives alone would restrict the opportunity to explore the issue of identity in such a way as to contribute useful knowledge, which may have practical, and policy implications for the management of childbirth.

As a means of gaining ethical approval according to the requirements of Research Governance (DH 2001), a specific number of respondents within each study group were required. The variation in the size of 'samples' in qualitative focused research is one issue, which poses great challenges for ethics committees who are more prone to approve experimental studies using specific probability sampling methods. Whilst I acknowledged that the use of smaller numbers of respondents was both adequate and appropriate within a qualitative framework, and should be judged in the context of the aims of the study (Streubert and Carpenter 1999), a definitive number of 20 respondents in each study group was considered adequate to achieve ethical approval. However, I drew upon the overall principles of appropriateness and adequacy (Morse and Field 1996) in relation to the experiences of the respondents and the richness and depth of data generated by the interviews, to guide my approach to the construction of the study groups. As a result I did accept the possibility that fewer than 20 respondents in each group would be sufficient to meet the aims of the study. I concur with Holloway and Wheeler (2002:128) when they state that in relation to qualitative research, 'sample size, however, does not necessarily determine the importance of the study or the quality of the data.'

Inclusion and exclusion criteria were required to ensure that the research met ethical requirements stated by the Local Medical Research Ethics Committee (LREC). The only inclusion criteria specified for the study group of midwives was that the midwife was an employee of the Trust. I was not interested in specific reproductive experiences and welcomed midwives to discuss a range of experiences with me. I was interested in listening to midwives' experiences of reproduction in general and I did not discriminate

between mothers and non-mothers. For the study group of mothers, specific criteria specified in Table 1 were used.

Inclusion Criteria: Women with live babies Age 18 years and over
Exclusion Criteria: Unwilling to participate Unable to speak English Converse to the above inclusion criteria

Table 1: Inclusion And Exclusion Criteria For Study Group Of Mothers Within The Postnatal Period.

Mothers who had their babies admitted to special care or had abnormalities were excluded due to the potential distress of the situation. Due to the lack of interpretation services, mothers who were unable to speak English were excluded from the research. Unfortunately this is a common problem in relation to some research undertaken in the maternity services, as practical, social and language barriers, together with a lack of time and expertise act to limit their involvement in research and therefore their views are seldom heard (Lockey and Hart 2007).

Advertising and Recruitment

A previous discussion with the Head of Midwifery had secured ethical approval and management support for the research. During the summer of 2004, I designed an A3 size poster with the technical assistance of the graphics department, in which the aims of the study and all my contact details were displayed. I distributed these posters to each ward area and community office in November 2004.

During my first visit I introduced myself to the midwife in charge of the ward and explained the study to her, and asked her to draw midwives' attention to the study. The posters were placed on the walls of the ward office in a prominent place for all midwives to see, together with information leaflets giving details about the study. During my visits I spoke to the midwife in charge of the ward and discussed the study. I explained the study to midwives I met and a number of them showed a great deal of interest. Envelopes with information leaflets and return slips were also left on each ward area and replenished on subsequent visits. With the use of stamped addressed envelopes, midwives returned the slips to me whereupon I would contact them and discuss the study further.

A slow trickle of slips and emails were sent to me highlighting interest in the study. By January 2005 I had interviewed four midwives. I started my visits again in February but as a result of work commitments I was unable to visit on a weekly basis as originally intended and monthly visits took place. I received no further inquiries until June and at this point I was feeling disheartened. In June 2005, two midwives approached me on the ward during one of my visits. They seemed keen to take part and they agreed there and then. I wanted to ensure that I had not coerced them in any way into participating by visiting the ward and therefore I gave them both the information and asked them to read it all carefully. Considering shift work and annual leave, the interviews took place two weeks later. A further two midwives subsequently made contact and agreed to be interviewed. After a year of advertising, I had interviewed eight midwives. Although I felt that the data were rich, I sent out flyers to all the wards and community office again, to remind them that the study was still in progress and I recruited another two midwives. A mass mailing to all the ward areas and community took place again in March 2006 and resulted in another four interviews. Although two other midwives had declared their interest in the study, planning time for the interviews proved too difficult due to their work and family commitments, despite exhaustive efforts. Therefore by the end of June 2006, I had interviewed a total of fourteen midwives. The decision to stop interviewing at this point was made in relation to the fact the process had taken nearly 18 months to complete and that pursuing other opportunities to recruit would delay the progress of the research especially when interviews with the mothers had not been started. Furthermore in my reading of the interview transcripts, I felt confident that the depth and richness of the data generated met the principles of appropriateness and adequacy and fulfilled the aims of the study. This is evident in the discussion of the midwives' experiences in the following data chapters.

THE USE OF A REFLECTIVE DIARY

A reflective diary was kept throughout the length of the research process and significant decisions about the design and progress of the research were noted. Writing about my experiences of childbirth was not easy. I felt reluctant to express my feelings at the beginning of the process, wishing to describe the situation, rather than engage with it. As I reflected in Chapter 2, I used a copy of my obstetric notes as a trigger to review specific experiences. In terms of the application of the auto/biographical approach, the use of

such a diary supported the reflexive nature of the research and enabled my continuous evaluation of the process as well as my feelings and emotions about the research. More significantly, following each of the interviews I made personal comments on the research, reflecting on the conduct and context of the research, my interview questioning, how I felt the whole interview had gone including my frustrations. In this context it helped me to consider my 'internal responses to being a researcher' (Etherington 2004:127). Occasionally, after visiting the hospital trust I would make some comment about any significant conversations or events that took place. Although I draw on a few occasional statements within this chapter to illustrate my responses and evaluations, I used the reflective diary in more detail as a way to support my analysis of the data. Comments written about the interviews were read and re-read in conjunction with the interview transcripts and supported the process of representing the accounts of midwives and mothers.

Personal reflections

The process of completing the interviews with the midwives did prompt my critical examination of the recruiting process. Firstly, I questioned whether my approach to recruitment could have been more persuasive in achieving a larger study group of midwives within a shorter time frame. I argue however, that by a process of poster distribution and hospital visits, I did maintain good ethical practice, even though the data collection had taken a long time. Whilst I thought originally that this approach gave me some 'control' over the recruitment process in terms of enabling midwives who truly wanted to discuss issues around reproduction to contact me, I had in fact little control over the size of the study group. If I had attended team meetings then I believe that I could have promoted the study more effectively; however whilst this was heavily influenced by my inability to visit the unit as often as I had planned due to a full time workload, I was aware of the potential influence that the senior staff could bring to bear on the midwives. To achieve a study group which conformed to what van Wissen and Siebers (1993) call 'uncoerced voluntary participation', I considered a process of distributing letters to all the midwives in the unit, with the use of posters to increase awareness of the study to be the most appropriate and gained Local Medical Ethics Committee approval. Although my specific experience of poor recruitment is not unusual as Hunter (2004a) describes an initial disappointing response to her research, I did speak to the senior midwives on the ward during my visits and anticipated that a snow balling

effect may take place. Whilst Matrons within the unit were also aware of the research I was reluctant to engage with a process whereby midwives were persuaded or coerced to take part. Having previously participated in research in which I had been nominated by a manager to be interviewed, I was aware of the importance of using a method of recruitment which avoided the potential criticism of institutional pressure. This is illustrated in the study by Lavender and Chapple (2004) for example, in which a focus group of midwives was obtained through a process of nomination and volunteer methods. They explain that 'For logistical reasons, midwives were nominated by the head of midwifery or volunteered to attend....' (Lavender and Chapple 2004:326). The process of nomination therefore raises the issue of whether respondents are chosen to support the aim of the study and in this example those midwives who would be more inclined to support the policies and agenda of the organisation. Furthermore it is important to consider that the nomination approach may place midwives in a difficult position, in which they could not express their opinions in a focus group situation for fear of retribution. Lavender and Chapple (2004) acknowledge this in so much as they accept the sensitivity of the information discussed and attempt to address it by taking notes rather than tape recoding the focus group interviews due to the potential vulnerability of the midwives in relation to their individual organisations. Although I accept that this method may be considered more suitable for some research, this was not a suitable method for my research.

Secondly, as the aim of the study was to explore the personal experiences and expectations of reproduction and childbirth, I appreciate the sensitivity of this study and the possible reluctance of some midwives to share experiences which they may have been unable to share with others. I do not use the word sensitive here to suggest that this research focused on a subject that is taboo; rather I consider it in relation to the intimacy of a range of experiences, which midwives may have gone through. Lee (1993:4) offers an explanation that may be useful here; he explains that some individuals may consider sensitive research as a 'substantial threat' in terms of the level of intrusiveness, which is the perspective that I consider potentially relevant here. During my visits a few declared their disinterest. I did not want to cajole them into explaining why they did not want to participate but their body language indicated that they were not interested. One midwife put her hands up and said 'No too busy' another said 'Research is not my cup of tea.' I include a thought from my reflective diary to illustrate my thoughts at that time;

Today I felt like a door to door salesman - the door was shut in my face

Another midwife declared her interest after the decision to complete the study group was made and it is interesting to speculate why she did not come forward earlier as she was aware of the study for some time; although she did have a senior position and therefore workload issues may have precluded her participation.

Thirdly, I considered the fact that the recruiting process had taken 18 months to achieve a study group of fourteen midwives. Although Furber and Thomson (2008) note that the process of data collection and analysis in their study of midwives' breastfeeding knowledge took place over two years, I too accept that this was not a limitation in relation to the context of my study, as the midwives were describing their own experiences of reproduction and childbirth rather than reflecting on specific practice policies which may have changed during the recruiting process. Although I cannot confirm the reasons why each of the fourteen midwives agreed to participate, each informed me that the topic was of great interest to them and that they wanted to share their experiences with me. Some may have participated for therapeutic reasons, in which their participation may have offered them the opportunity to discuss issues, which they had had little opportunity to discuss previously. In this context being interviewed can act as an intervention, in which there is some therapeutic benefit to discussing personal experiences (Sque 2000). The biographical details of the study group of midwives are presented in Appendix 5.

RECRUITMENT OF MOTHERS

Having completed the interviews with the midwives, I was determined to complete the interviews with the mothers in a more reasonable timeframe, and as a result of my reflection I approached the recruitment of mothers in a different way. In the absence of a Head of Midwifery who had now retired, letters were sent to the matrons and a meeting with each one took place to guarantee that the current midwifery managers were supportive of the study. Large posters had been distributed and displayed on all ward areas and the community office during the recruitment of midwives and whilst staff had taken some down, new posters were used to inform them of the interviews with mothers. An A5 flyer was devised to give an idea of the study and included all my contact details. A bundle of flyers were left in prominent areas such as the communal areas on the wards and copies were also placed in each community midwife's pigeonhole and replenished

during every 2 weeks during my visit as required. Ten information packs which included an information leaflet and consent form and stamped addressed envelope (s.a.e.) were left on each of the three wards and community office, to be given to mothers who showed willingness to participate. During each visit I spoke to the senior midwife and staff on the wards to draw their attention to the study and the study criteria. A poster was placed on the notice board in the ward office detailing the purpose of the research, together with copies of the information leaflet and consent forms.

Mothers were recruited mainly as a result of direct contact from myself during visits to the wards. During my visit I approached the midwife in charge and asked whether she had mothers on the ward who fulfilled the criteria for the study. She identified mothers who were suitable and I would approach them to discuss the study. In this context she assumed the role of gatekeeper (Holloway and Wheeler 2002), identifying mothers who were suitable and those who were unsuitable as a result of not being able to speak English, mothers who were either ill or had babies who were in the Special Care Baby Unit or those who were younger than 18 years of age. I accepted that this role was important to support my aim to conduct ethical research, as her knowledge of individual mothers would act to protect the mothers from unwarranted intrusion from myself as a researcher. On reflection, the occupational representation of the study group of mothers (Appendix 5), suggests that midwives may have used their own judgement to select those mothers who were more educated and articulate and as other studies have suggested more likely to support and participate in research.

During my visit, I wore my University identity badge, which stated Senior Lecturer; I would verbally introduce myself as a midwifery lecturer from the university who was doing research. I asked them whether I could explain my study to them and added that there was no obligation to take part. Some mothers were very interested and agreed to take part 'on the spot' whilst others were more hesitant. Where mothers were keen to take part, I would note down their details and arrange to contact them after they returned home to arrange an interview. I gave them an information pack with a consent form to read prior to my contact and suggested that if they had any questions that they could ring and ask me at any time. Mothers who were hesitant were also given an information pack with all the details and they were asked to ring or email me if they wanted to take part; none of these mothers made any further contact. I did not feel comfortable enough to

obtain their details and follow them up by telephone as I sensed from their body language and their general verbal response that they were not interested.

Since I was aware of the upheaval and general tiredness of returning home with a new baby, I specified within the ethics application that interviews would take place within the first six postnatal weeks. I considered that it would be more practical to interview mothers within this time period to accommodate practical issues of returning home with a baby and to enable the mother to recover from the delivery. Following my initial meeting with the mothers on the ward, I allowed the mothers to have had at least a week at home before arranging the interview. This also allowed them time to consider their participation in the study and enabled me to feel more satisfied with the fact that I had gained their informed consent and that their participation could not be questioned on the grounds of coercion. Some midwives also gave mothers the information packs and I received two declarations of interest via this route. The return slip had all their contact details and I was able to ring them to arrange an interview.

Although I originally intended to interview a study group of twenty mothers, 15 mothers agreed to the interviewed between February 2007 and April 2007. Of the 15 mothers, 13 mothers were interviewed. Whilst appointments were made with the remaining two mothers, one rang to cancel and explained that it was not convenient and did not want to arrange another interview; the other mother was not at home on the two occasions that we had arranged to meet. I did leave a message on her mobile to explain that I had called and that there was no one home but I did not receive any further response. The decision to complete the interviews within three months was determined by the fact that this reflected the working environment of the maternity unit during a specific time period and that extending the period of interviewing any further may have compromised elements of the data, especially in relation to organisational changes which were due to take place within the unit at that time i.e. rotational changes between hospital and community. The recruitment of mothers was a far more positive and encouraging experience due to the approach used. Some months later a mother rang me and requested an interview but she had birthed her baby some six months earlier and was outside the focus of the study. During our conversation we discussed her experiences and considered them in the context of the research.

CHARACTERISTICS OF THE STUDY GROUPS

Appendix 5 and Appendix 6 detail the biographical details of both study groups of midwives and mothers. This is included to allow the reader to engage with each respondent in both study groups to facilitate further engagement with the theme chapters. An overview of the biographies of the midwives and mothers is added to consolidate this engagement with the respondents and aid transparency.

Of a total of fourteen midwives, eleven midwives were mothers and three were non-mothers; all three expressed a desire to have children in the future. Between them, the midwives had 26 children with ages ranging between 3-28 years of age; two midwives had experienced a miscarriage and one had experienced a sudden infant death. The age of midwives ranged between 20-50 years of age; two were in their fifties; five midwives were in their forties; five were in their thirties and two were in their twenties. Eleven were married and 2 were divorced and co-habiting; one midwife was single. Although ethnicity was not explored; twelve midwives were Caucasian and two were non-Caucasian. Five midwives had completed their midwifery education by a pre-registration midwifery programme within the last 7 years; nine completed the shortened post-registration programme more than 7 years ago following registered nurse training. Seven midwives worked part-time hours and the remaining seven worked full time.

Of the study group of mothers, their age ranged between 19-41 years of age; one was in her forties; nine were in their thirties; two were in their twenties and one in her teens. Ten mothers were married; two were single and one was co-habiting. Although ethnicity and social class were not examined specifically as these were not the focus in relation to identity, all mothers within the study group were Caucasian. To determine the social class position of the mothers within the research, the National Statistics Socio-economic Classification (NS-SEC), (ONS 2000) was applied on the basis of their current or previous employment. This classification is illustrated in Appendix 6 where it is shown that the majority of mothers were classified as group 3 Associate Professional and Technical Occupations. One mother described herself as a housewife which is not included in the classification system and is therefore indicated as not stated (N/S).

It is noteworthy that of the thirteen mothers interviewed six had caesarean section. This is a typical finding and is representative of maternity units, since the Caesarean section

rate within the UK has increased to 24% for births between 2006-2007 (NHS Information Centre September 2008).

USE OF IN-DEPTH INTERVIEWS

In-depth interviews (also known as unstructured interviews), were used as the method of data collection (Reinharz 1992). This method was considered appropriate to reflect the feminist principles of achieving a more holistic understanding of respondents' experiences within a reflexive, reciprocal and emancipatory framework. In-depth interviewing is based on three assumptions. Firstly it is a way of understanding the respondent's world through empathetic appreciation. Secondly participation in in-depth interviews should be a mutually beneficial experiences in which it can help 'the subject uncover suppressed feelings through the interview process, the researcher also gains knowledge of his or her own hidden or conflicting emotions' (Johnson 2002:106). In-depth interviewing goes beyond the 'actual interview interaction', in so much as it enables respondents to reflect on issues, uncover painful and distressing matters which lie unresolved and can influence respondents perspectives. Thirdly I argue that in-depth interviewing enables a multi-perspective understanding of the issues, in which the conversational nature of the interview enables the respondents to disclose a range of experiences in which a fusion of horizons or shared understanding can be achieved.

Much feminist work is characterised by multiple interviewing (Reinharz 1992), as a means by which a strong reciprocal relationship can develop between the researcher and the respondent. The opportunity for a more prolonged engagement with the respondent through a processual approach is considered to be useful in the production of rich data. However Lee (1993) suggests that a single interview may encourage a more in-depth exploration of issues because of the limited contact with the researcher. Initially I planned that all respondents would be interviewed on two separate occasions but when I considered the context of the research and the benefit of revisiting each respondent, a single interview was considered to be more appropriate. Moreover I considered that the focus of discussion would lend itself more to a single interview rather than a series of interviews.

I decided to approach one study group at a time so that following the completion of one complete group of interviews analysis could be completed before embarking on the

second. Any interesting issues could be followed up with the study group of mothers and explored from their perspectives. All but two of the interviews were undertaken in the respondent's home. Of the fourteen midwives who participated, two were conducted at the University at the request of the midwives. One interview was conducted prior to a clinical shift and the other at the end of the shift as the midwife lived an hour away from the hospital. Although interviewing at home allowed the respondents and myself to feel more at ease, for the two interviews conducted at the University, choosing a comfortable and confidential area was more difficult. The first interview was undertaken in a small teaching room; the room was clinical, with desks and chairs and was not what I considered to be the ideal environment for an interview. Nevertheless the midwife felt able to discuss her experiences at length. To illustrate this point I include an excerpt from my reflective diary:

I met her at the agreed location... I had terrible trouble parking and it's been raining hard: we were both soaked! Since I had met her before, we agreed to go for a coffee before we started the interview. The only confidential venue I could find was a windowless seminar room that was cold, clinical with a central strip light. The chairs were plastic and school-like. My initial idea of finding a comfortable environment etc was immediately destroyed. As there were no alternative rooms available I had no choice but to accept this. I was afraid that it would not be conducive to a thoughtful interview. I thought this would be a total disaster – but we talked for nearly 2 hours.

In this situation, the interview felt very positive and generated useful data. For the second interview, I looked for a more comfortable location and found a small room in the library with easy chairs, which offered a quiet and confidential location.

A nicer room today; I think I'll use this one again if I need to. I felt comfortable and I think she did too. She talked about very sensitive issues, which I think she wouldn't have if she'd felt uncomfortable with the location or with me

Conduct of interview

Each respondent interviewed at home welcomed me and offered me a cup of tea or coffee on arrival. I felt very relaxed from the outset although quite apprehensive about whether midwives and mothers would speak to me. Some had children present or a mother ironing in the background or a partner in another part of the house. In one interview, the midwife was supervising her young children playing in the garden and so the first half of the interview was conducted outside on the patio. In another a toddler frequently joined us and the midwife had to break off the interview to provide fruit and drinks. Of the study group of mothers, some actively breastfed and changed their babies during the interview. At times I felt myself drifting into a community midwife role since

mothers were within the first six weeks. Although I had anticipated that mothers might ask questions about specific clinical concerns which would have challenged the boundaries between the professional and the researcher, mothers were generally relaxed and did not express any clinical concerns.

Before I started the interviews I obtained consent and asked them a few background questions e.g. age and occupation. Since I was unaware of the midwives reproductive histories I started their interviews by asking 'Tell me something about yourself.' When I interviewed the mothers, I had already ascertained their recent experiences when I saw them on the ward and therefore I started the interview by asking them 'Tell me something about your birth experiences;' these opening questions enabled me to pick up on a number of issues and facilitated a free-flowing style to develop. I wanted the interview to adopt a conversational style. This resembled the conversations within the midwife mother relationship. This echoes Oakley (1981b:57) who argued that: 'a feminist interviewing women is by definition both 'inside' the culture and participating in that which she is observing'. Being a woman means that the researcher can personally identify with the women she interviews and the women identify with her, so that: '...personal involvement is more than dangerous bias - it is the condition under which people come to know each other and to admit others into their lives' (Oakley 1981b:58).

Although I avoided using a strict framework for the interviews to promote a conversational approach, I had identified from the existing literature issues such as midwives as mothers, male midwives and breastfeeding, which were derived from the scant literature on midwives experiences around birth. During the interviews, I would use appropriate moments to explore these issues. I interrupted the respondent at times and asked them to clarify points by asking 'what do you mean by that?' 'Why do you say that?' 'Tell more about that.' This technique enabled further exploration to take place.

Throughout the interviews I encouraged the respondents to tell the story about their experiences. The biographies of the midwives and mothers give some indication of the range of experiences disclosed and the emotional intensity of some of the accounts. The emotional nature of some interviews was intense, especially in interviews conducted with midwives. The opportunity to discuss reproductive and childbirth experiences may not be as forthcoming for midwives in comparison to mothers. Bewley (2009) in her study of midwives' experiences of personal pregnancy loss, describes midwives participation in the

study as providing them with 'some kind of resolution' (Bewley 2009:151). Whilst I had planned the protocol to deal with respondents who become distressed, Alice in recounting her experience of being present at the traumatic delivery of her grandchild became very tearful but continued with the interview at her own request after a brief pause. She thanked me after the interview and hoped that her experiences would help others.

I did not make notes during the interview, as I believed that this disrupted the eye contact between the respondent and myself. I often made brief notes in my reflective diary when I got back to the car. I often got a 'gut feeling' as to whether the interview went well or not. All were enjoyable and I felt that I had enabled them to talk and offload about issues, which they would not have had an opportunity to do otherwise. This was particularly true of the interviews with the study group of mothers. One of the interviews with the midwives however seemed initially disappointing although I did obtain interesting data when I started the analysis. It seemed really difficult to get her to talk about her experiences in any great depth. She seemed pleasant and welcoming and we started the interview in the usual way accompanied by a cup of tea. During previous interviews midwives started describing their experiences, some of them recalling experiences of very early pregnancy. However in this one interview, interviewing was rather more challenging and required more of me as the interviewer in relation to questions I asked.

Two particular phrases were repeated during the interviews, which reflected an acknowledgement of my status as a researcher. When recounting particular experiences, midwives at times refrained from going into great technical detail by saying 'as you know.' At other times the phrase 'you know what I mean?' was said at the end of a particular response. These raised concerns as to the depth to which midwives and mothers would go to explain their experiences to me, knowing that I was a midwife. In order to gain their full horizon as discussed in Chapter 2, I would consciously note the tone of the response and prompt them to explain if I felt that the context of the response required clarification.

I have previously discussed in Chapter 2 the issue of reciprocity and positionality and the vulnerability of the researcher in relation to the research; I will now expand on this point further. As a researcher, a mother and a midwife, my own biography enabled me to become an 'insider.' Within an auto/biographical approach the researcher invests of her

self within the research relationship in terms of disclosing aspects of her own biography with the research. Maintaining a balance between 'disclosure' of information and the 'exposure' of self in terms of the vulnerability of the researcher may not be straightforward. The intensity of emotional dialogue may generate conversations, which become distressing for the researcher as much as the respondent. Gruppetta (2004:2) writes:

Honest autobiographical exploration generates a lot of fear and doubt. There is emotional pain and the vulnerability of revealing yourself, and having no control over how readers interpret what you have written, nor are you able to take it back.

Whilst disclosure and exposure as concepts contribute to a loss of power and potential exploitation within the research relationship, I felt that the respondents saw themselves as 'knowers' and as such were contributing their experiences to an important cause. Conversations before and after the interviews reflected a comfortable and secure environment and encouraged general discussion. This supports the fact that during the interviews none of the respondents asked me whether I had children or what my experience was like. Some asked me before or after the interview to either establish my agenda or to consolidate their participation but did not ask for a great detail of details. I consciously resisted including my experiences in every interview because I felt that my contribution was not of any benefit to the interview. There were times however, when a reference to a similar experience was useful whilst in other interviews my experience is absent.

With the aim of establishing a reciprocal relationship, imbalance between disclosure and exposure may influence the data and affect the ethical conduct of the interviews; how and to what extent the researcher maintains that balance is debatable. Letherby (2003:98) illustrates this point:

To balance the vulnerability and risk that respondents may have felt in terms of disclosure, and in an attempt to 'equalise our relationship', I was concerned that each interview should contain as much of my experience as my respondents asked for. I referred to my own experience to varying degrees in different interviews, and I realised that my desire to invest myself within the fieldwork stage of the research was at least in part structured by the wishes of respondents. They all asked me why I was interested in this particular topic. Once told, most appeared to accept this as sufficient justification for my interest and it was rarely mentioned again.

Some respondents may not welcome this disclosure. Webb (1992:419) suggests that while this approach 'seemed to have a positive effect and encourage rapport'; later she

describes her experiences in another study where sharing personal information 'did not seem to be welcomed'.

Against this background it is important to consider how beneficial in-depth interviewing has been for me personally. It has been a very emancipatory experience in which I was able to reflect on my own experiences as discussed in Chapter 2 and consider how they had influenced my attitudes. Until I started interviewing I had not realized the effect that these specific experiences had had on me. I was unaware of how much I wanted another baby even though when I started the research itself I was set for an academic career and one child seemed enough. The process of obtaining my own notes was the first step that led to many discussions; writing these chapters has been immensely enjoyable although emotionally hard at times.

Developing and revisiting preunderstandings

I developed my preunderstandings from the discussion of issues from within the existing literature and drew from my own experiences to identify what my thoughts were and potential biases. This was a gradual process that developed as I considered the focus and structure of the research proposal. As I started to read the literature I developed a more concrete set of preunderstandings, which centred on midwives perception of their experiences as mothers, their experiences of midwifery. In relation to mothers I believed that mothers would be disillusioned with the care that they receive in view of the shortage of midwives and the conveyor belt approach that exists. As a result I believed that some mothers might be quite critical of midwives. After I started interviewing I began to unconsciously revisit my preunderstandings as I reflected on the interviews.

Recording and transcribing

All interviews were audio tape-recorded with the permission of the respondents. The first few interviews were recorded with the aid of a manual tape recorder. This was difficult to position and the clarity of the interview recording in places was affected. Following this experience I obtained a digital recorder, which was easier to use, and the quality of the recording was much better. This type of equipment also enabled the recording to be saved onto disc, which was used as a method of back up.

The interviews were taped and lasted between 45 minutes and 2½ hours. All the interviews were transcribed verbatim. Following the initial period of data collection, I

found that the process of transcribing the four completed interviews had fallen behind schedule. I found the transcribing process very difficult as I did not possess audio-typing skills and it took me days to transcribe one transcript. I was recommended a transcribing service through the University; this was a private company which was registered under the Data Protection Act 1984 and as such assured me that all the transcribing remained strictly confidential. From a total of twenty-seven interviews I transcribed five. All transcripts were checked for accuracy and meaning, amendments were made if required. Obstetric and midwifery terminology was clarified.

Data were anonymised to protect the identification of each respondent and the maternity unit. Each respondent was given a pseudonym; children's names, husband/partner details and references to ward names and staff references were also changed. It is pertinent here to add that all pseudonyms were chosen and allocated by myself following the interviews and prior to the transcribing of interviews. As I did not refer to any respondent by name during the interviews, their identity was protected during the transcribing process. This was considered to offer additional anonymity.

From the study group of midwives, most of the children were aged between 3 and 28 years. Although this may suggest some 'recall bias' especially those who had birthed their children over twenty years ago (Ann, Grace and Alice), strong traumatic or meaningful events which are emotionally significant are considered easier to remember (Christianson 1992).

To conclude the discussion of the methodology discussed in this chapter, I consider the analysis of the interviews. I discuss the development of a specific analytical method that reflects the methodological approach employed within the research.

ANALYSIS OF INTERVIEW DATA

The methodological approach introduced in Chapter 2 and developed here, places the focus on the meaning of the experiences of reproduction and childbirth for the study groups of women not on the language alone. The aim of the interview approach within the auto/biographical framework was therefore to generate 'rich and nuanced descriptions of the phenomena' (Kvale 2007:107)

Selecting a method of analysis, which embraced the philosophical thinking of Gadamerian hermeneutic phenomenology to support a reflexive auto/biographical position, was problematic for three reasons. Firstly, it is important to consider the context of the analysis. Gadamer did not propose a research method or analytical approach, he opposed the use of method and suggested that hermeneutics is an attempt to overcome it. This creates tension as any form of enquiry, which aims to reflect Gadamer's philosophical thinking must be 'true' and consistent in this way, since it may open to criticism. One danger here is that in an attempt to develop a method of analysis, the researcher may be guilty of over simplifying the application of Gadamer's work. I may be judged to be guilty of this. Turner (2003) explains:

Although numerous contemporary research textbooks incorporate discussion on data analysis...these texts often do not provide detailed descriptions of how to undertake data analysis when a study is conceptualised using particular philosophical orientations, and some omit discussion about analysis of qualitative data altogether.... (Turner 2003:18).

Whilst researchers (Clarke 1999; Fleming, Gaidys and Robb 2003; Turner 2003) have reported the development of 'methods' consistent with Gadamerian philosophy, it is clear that inconsistencies in the interpretation and use of terminology exist between them. Although Carter (2004) suggests that:

....producing a step-by-step recipe of 'how to do analysis' ultimately destroys the creativity and flexibility inherent in the analytical process (Carter 2004:87),

the preoccupation with method reflects an eagerness to gain recognition within academia but also as a means of making qualitative research more acceptable within health care science. However, if the aim is to advance knowledge, academics need to place their heads above the parapet to initiate constructive debate; this is what I have attempted to do within this research.

Secondly the method of analysis detailed here is inspired by the work of Fleming, Gaidys and Robb (2003), who propose a Gadamerian-based research method and also the work of Clarke (1999), who presents an approach to hermeneutic analysis. What is central to both, is the need for the development of themes, although others have claimed that thematic analysis is more in keeping with Husserlian phenomenology (Koch 1995; Walters 1994). Although I would argue that thematic analysis is more suitable to the context of this research, I suggest that the analytical approach adopted here could be described as a 'hybrid approach of qualitative methods' (Fereday and Muir-Cochrane 2006). The process

of analysis set within a hermeneutic context, must be systematic and cyclical, although Clarke (1999) emphasizes that a staged approach to analysis is not commonly associated with hermeneutic phenomenology. Therefore I would argue here that in order to complete hermeneutic analysis and gain understanding of the phenomena being explored, a specific analysis process must be adopted. For this reason I detail the stages developed.

Hearing and writing the reproductive biography

I read each transcript multiple times whilst listening to the tape; notes were written in the margins to indicate initial thoughts and ideas. Using Gadamerian hermeneutics in this way enables the meaning of the whole text to be determined before the meaning of each individual part can be analysed; therefore 'the meaning of the whole will influence the understanding of every other part.' (Fleming, Gaidys and Robb 2003:118). I constructed a detailed biography of each respondent reflecting the reproductive history, experiences of work and motherhood. However, although this is narrative in nature, it essentially incorporates my interpretation as the researcher. This process enabled me to engage with the respondents and start to understand them as individuals. The experience of writing the biography is reflexive and facilitates researcher reflection which in the Gadamerian tradition, challenges preunderstandings of the phenomena. Having already started to question my preunderstandings following interviews, I began to find more mutual understandings developing from the reading and rereading of transcripts and listening to the recordings.

Hermeneutic interpretation - developing meaning

Having established an understanding of the whole, each section of the transcript was then explored in order to identify relevant themes. I used a process of thematic analysis to enable the development of themes based on my interpretation of the interview data. I did not consider or participate in a process of thematic analysis that could be considered as quantification, in terms of the numerical counting of phrases and words. Whilst coding may be defined as a process of data reduction and therefore inconsistent with hermeneutic principles, I argue that the process of developing in-vivo coding (Strauss 1987) enables closer in-depth engagement with the data, as a preliminary step, in which the meaning of each sentence or section can be related to the meaning of the text as a whole. Although I used the qualitative data analysis programme Nvivo (Richards 2006), to

name, label and attach codes to sections of the transcript, this was performed as a process of organizing data rather than a means of gaining understanding. Gibbs (2002:11) confirms this approach when she argues that: '... the program will never do the reading and thinking for you.'

Rather my use of thematic analysis enabled immersion and engagement with the data in a fluid way, which could be described as an iterative/thematic analysis process (Hansen 2006), in which the researcher moves between collecting and analysing data. This was achieved by the use of the two study groups where one group was interviewed first and analysis was undertaken prior to the second interviews. Although Turner (2003) considers thematic analysis to be inconsistent with Gadamerian philosophy and more in keeping with Husserlian phenomenology, the development of new understanding based on my interactions as the researcher with the respondents, can be achieved by thematic analysis in which the researcher can become intimately involved with the researcher dialogue. This process is further enhanced by the researcher's ability to use reflexivity to support the notion of creating a fusion of horizons. Whilst some researchers who employ Gadamerian hermeneutic phenomenology, explore specific concepts that lend itself to the development of dominant horizons (Turner 2003), in the context of this research, I argue that the development and presentation of themes is more appropriate.

Construction and presentation

Having discussed how I engaged with the process of thematic analysis and the use of computer package as a data management tool, the construction of specific themes demanded that I returned to the paper transcripts on a regular basis to consider the context of the interview rather than depend on coded extracts alone. Each transcript was again examined closely and specific passages, which represented my interpretation of the respondents' words, were identified. Whether the term theme or horizon is used, the interaction with the data results in the identification of specific passages, which reflect mutual shared understanding between the researcher and respondent which should provide the reader with an insight into the theme being discussed (Rudolfsson, von Post and Eriksson 2007).

CONCLUSION

This chapter details how the process of 'auto/biographical practice' supports the feminist theoretical position discussed in Chapter 1 in relation to the production of accountable knowledge (Stanley 1999) and also illustrates the practical aspects of positionality and reflexivity considered in Chapter 2. My aim to plan and conduct good ethical research is confirmed by the discussion of ethical issues and my justification for decisions made. This is especially significant in relation to the conduct of the interviews and the exploration of emotional issues that may be as significant for the researcher as much as the respondent. Adopting a reflexive position within an auto/biographical approach is challenging and this chapter has detailed my experiences and reflections of recruitment and interviewing. Personal reflections enhance the understanding of the lived experiences of conducting research, but also illustrate the potential vulnerability of the researcher when a reflexive approach is adopted. In this chapter I have illustrated how the methods of data collection and analysis were used to achieve the aims of the research and further develop the theoretical and methodological discussions in Chapter 1 and 2.

The next four chapters present the themes identified by the analysis of twenty-seven in-depth interviews. These chapters are sequenced to reflect the development of the midwife's identity from the time she embarks on the profession. Chapter 4 sets the scene for the next three chapters by illustrating how midwives broadly define midwifery and how they understand what it means to be a midwife. I consider the midwife's identity in relation to reproduction and midwifery and suggest that this is a problematic relationship between professional expertise, childbirth and the making of maternal identities.

In Chapter 5, I discuss the reproductive identities of midwives and consider the tension between their reproductive identities as mothers and their professional identities as midwives. In Chapter 6, I develop the professional identity of the midwife further in relation to the construction of the identity of the 'good midwife.' In Chapter 7, I conclude the discussion of the data by focusing on the relationship between the mothers and midwives and the provision and context of midwifery care. The structure and presentation of the four data chapters not only reflects the primary focus on midwives but also the relationship between midwives and mothers, that is Chapters 4 and 5 focus predominantly on the midwives, whilst Chapters 6 and 7 discusses data from midwives and mothers. This is a deliberate strategy to illustrate the development and construction

of identity of the midwife and also demonstrates how mothers' experiences' support and influence the midwife's identity construction.

CHAPTER 4

CONSTRUCTING A MIDWIFERY IDENTITY

INTRODUCTION

In the first of four data chapters, I discuss the data from the analysis of in-depth interviews with fourteen midwives, with a view to exploring the research question 'How is the identity of the midwife constructed?' The data suggest that the identity of a midwife is socially and professionally constructed in relation to the stereotypical representations of the female caring role. This will be explored in relation to the reasons why the midwives within this study decided to embark on midwifery. In this chapter I consider the importance of embodied knowledge within the process of professional socialisation in terms of the presence or absence of the experience of motherhood and nursing.

The culture within which midwifery is practised reflects both the midwife's understanding of her professional identity and the philosophy of midwifery care. For this reason I start this discussion by focusing on the context and culture of midwifery practice in relation to the fourteen midwives interviewed. In the first part of this chapter I develop the discussion to focus on the notion of becoming as an aspect of identity development. Midwives' reasons for embarking on a career in midwifery are considered in the context of two underpinning and interrelated themes of caring and experience. The social meaning of caring in relation to nursing is explored; and care in relation to the role and experience of being a mother is considered to reflect the positioning of midwives. In the second part of this chapter I develop these themes further in relation to the relationship between identity and knowledge. The accounts of midwives in relation to their own learning as students and as mentors of students with and without children will be explored. This discussion considers the contribution and tension between authorised or expert and experiential knowledge. The third and last part of this first chapter develops the discussion further by placing the focus on the identity of the midwife as a professional. This discussion will consider the elements of the midwife's professional identity, based on the accounts of midwives' experiences of the transition to professional practice.

IDENTITY AND THE CULTURE OF MIDWIFERY

Making the decision to embark on a career in midwifery is the first step in the process of acquiring skills and knowledge necessary to fulfil the role of a midwife. In order to make this decision, women will have acquired an interest and a broad understanding of the role in some way. Whilst the process of registration legitimises the professional and public expectations of accountability and responsibility in the care of women, babies and their families, midwives develop a sense of a 'professional self' in relation to their understanding of themselves as accountable practitioners. In this context the midwife internalises her attitudes, beliefs and behaviour in relation to what it means to be a professional. Developing a professional identity as a midwife is one, which is therefore guided and influenced by a formal programme of education, consisting of both theory and practice.

During a process of socialisation (Elston 2005), the student midwife develops an understanding of what it means to be a midwife in a professional capacity; she learns about the 'how, when, where and why' of midwifery. In other words, students throughout their programme of education 'learn the culture' of midwifery (Gray and Smith 1999:640). However, an understanding of what it means to be a professional can change over time as a result of personal and professional experiences, political and professional policies and practices, social and economic factors (Larsson, Aldergarmann and Arts 2009). Therefore it is also important to recognise that a midwife's understanding of her professional identity does not remain constant and as a result can influence her decision to stay or to leave midwifery. The introduction of new practices, models of midwifery care can challenge and threaten well-structured systems of working and personal philosophies of midwifery (Kirkham 1999). A negative effect of this is frustration and disillusionment and a loss of professional and personal identity (Ball, Curtis and Kirkham 2002).

Eight (Anita, Ann, Chris, Grace, Jackie, Lucy, Trish, and Kirstie) of the fourteen midwives interviewed completed a nursing qualification prior to embarking on midwifery; the remaining six midwives (Alice, Vicky, Rebecca, Susan, Tracey and Julie), completed a pre-registration midwifery programme as direct entrants, without a prior nursing qualification. Broadly, the accounts of these two groups of midwives represent two different periods of time where the provision of midwifery education reflects differences

in the corresponding culture within midwifery. Midwives, who had previously registered as nurses, completed their midwifery education during a time when the majority of educational programmes were offered on a post-registration basis for qualified nurses. Whilst pre-registration midwifery programmes had been offered since 1968, by 1988 only one school in England offered the programme. However, following a study by Radford and Thompson (1988), seven pilot schools were supported to develop and provide pre-registration midwifery programmes, resulting in over three quarters of midwives being prepared in this way by the 2000. Furthermore these eight midwives completed programmes of midwifery at a time before the woman-centred philosophy of care had been formalised by the publication of *Changing Childbirth* (DH 1993), reflecting a culture where there was little consumer choice and shared-decision making. This is a significant point here, as the knowledge and understanding of midwifery can be heavily influenced by the culture within which it exists.

Grace's account of her career over thirty years, summarises the current culture within midwifery and highlights some of its more complex issues:

I am much more laid back. I think working in a busy unit, a consultant unit, you do look at the complicated far more but I am trying to revert back to being normal. Two years in my GP unit where I worked [...] we didn't have a monitor in sight and that was a great, initially I was quite scared because you are just relying on your clinical skills, no equipment, certainly no backup, if you needed backup you had to get a GP in or an ambulance to transfer the patient to the consultant unit, so you actually looked at your clinical skills and I think working in a bigger unit you are always, you have always got litigation at the back of your mind these days and I think you are watching over your shoulder the whole time. I would like it not to be like that...but I don't know about my practice, I try to be as normal as I can with every patient...I try and encourage them to be thinking normal midwifery, less intervention, less analgesia, therefore hopefully less intervention.

[Grace-midwife and mother of two children]

She makes some comparisons between the philosophy of midwifery care in the General Practitioner (GP) unit and the Obstetric Unit. Within the GP unit the midwife is the lead professional whilst in the Obstetric unit she feels less autonomous in her decision making due to focus on complicated pregnancies. The demise of GP units on one hand signifies the move towards hospitalised birth and the changing role of GP's in the provision of obstetric care and midwifery support; on an other the absence of a contemporary alternative for low risk mothers suggests the lack of financial investment in the geographical area.

Her account illustrates some of the key frustrations that midwives express in relation to midwifery practice within obstetric-led units today. She suggests a struggle in the

provision of normality within the Obstetric unit, which as discussed in Chapter 1 is not uncommon and leads to a great deal of frustration. Maintaining the emphasis on the normal seems difficult. Her account emphasises her primary concern to maintain normality and reduce intervention. The issue of midwifery skills is also pertinent to Grace's account of her experience of current practice. She determines that within an Obstetric unit she has little opportunity to use the clinical skills she has developed whilst working on the low risk GP unit. She highlights the suspicious nature of practice in which she feels she is under surveillance. Her account reflects an uneasy environment created by the risk driven litigious culture in which practice becomes defensive rather than based on women's needs. This account highlights some of the key issues within the culture of midwifery today, where the location of birth dominates the organisation and structure of services but also the culture within which midwives work and the way in which midwives practise.

THE RELATIONSHIP BETWEEN NURSING AND MIDWIFERY

Midwives within this study recounted their experiences of entering midwifery as a response to my question 'Tell me something about yourself'. For some their accounts of midwifery were a very specific aspect of their biography, which they considered at length, whilst for others their focus was more on their childbirth experiences, for which I felt the need to ask them specifically 'Why did you become a midwife?' This was a very important line of enquiry, which aimed to establish the motivation to become midwives; I was interested to explore any underlying personal experiences, which may have motivated them to embark on midwifery as a career. Women entering midwifery may have varying ideas of what midwifery is, influenced to a great extent by their engagement with reproduction and childbirth, whether as mothers, maternity health care assistants, nurses, or in other ways.

The decision to embark on midwifery as a particular healthcare career was variously described by midwives within the study. Although many of the midwives could not clearly articulate the reasons why they wanted to be midwives, Anita, Ann, Chris, Grace, Jackie, Lucy, Trish, and Kirstie, placed some significance on the fact that they had completed a nursing qualification first. Completing a nursing programme first was a means by which many women at that time would progress onto a midwifery programme. Nursing was the main route into midwifery until the late 1980s' and many midwives placed a great deal of

emphasis on the currency associated with being 'dually qualified.' This is in fact the advice I was given in relation to future career prospects. Currently, the distinction between nursing and midwifery was less clear as 'nurse training' was considered to provide the basic skills of care, necessary to enable an individual the opportunity to 'specialise' in an other area of healthcare such as midwifery. This emphasis on being part of a caring profession therefore reflected the midwives identity as a healthcare professional in which the focus was placed on being 'a helper in care' (Symonds and Hunt 1996: 204).

Although these eight midwives had experience of nursing, midwifery appeared to have been their chosen careers, reflected by the number of years they have practised. What is clear, especially in Grace's account, is that midwifery is a life long commitment and as such could be considered as a vocation. Throughout the interview Grace refers to the fact that she has been in midwifery for 30 years and it is an important part of her life. For Grace her professional identity has become a dominant social identity, where her life revolves around her work:

...started nursing at 16, I was a nursing student in the late sixties so nursing and midwifery has been my whole life....

[Grace-midwife and mother of two children]

Having been a midwife for over twenty years, Chris, considers that nursing was a route to a career in midwifery for her:

I don't know, I just always wanted to be one, and that is why initially I did my nursing for to then go onto to do midwifery. I did my general RGN training and then I went on to do district nursing. I didn't like being confined to the hospital but still wanted to be a midwife, in them days you didn't do direct entry....

[Chris-midwife and mother of three children]

However, within her account she explains that whilst her career as a nurse was based in the community where she had more autonomy, her use of the word 'confine' suggests that she recognises the lack of autonomy within hospital based midwifery practice. In spite of this, her account suggests that she is happy to accept that her desire to become a midwife exceeds her dislike of hospitals. Undertaking a nursing qualification first, gave some women the opportunity to check out their suitability for midwifery. Kirstie, Trish and Lucy described ways in which they had gained experience of health care settings as a way of confirming their suitability for midwifery as a career:

I was a nurse, I did my general training... worked for the year as a Staff Nurse, then did 18 months as you had to do then in midwifery and I have been in the job ever since.

[Ann-midwife and mother of two children]

I became a midwife, as a staff nurse I did my midwifery training and I just loved my midwifery placement, absolutely loved it so I decided I am going to be a midwife.

[Lucy-midwife and mother of two children]

In this context, midwifery is seen as a very different profession from nursing which demands a different approach, which could be considered in terms of the nature of the work and the perceived maturity required to fulfil the role of the midwife. It is also suggested here that these midwives recognised that the identity of the midwife was different from that of the nurse. Kirstie, like Chris and Grace, (and myself), could not clearly articulate her reasons for becoming a midwife. She knew that it was something that she wanted to do but identified the need to gain experience of nursing first:

I think I always wanted to be a midwife but I wasn't really sure because I had no nursing background, so I thought I would do nursing first to make sure....

[Kirstie-midwife and mother of three children]

She uses this experience as a way of checking out midwifery and also confirming her suitability for midwifery. In this context whilst she considered midwifery to be quite different from nursing, she considers that the experience of being a nurse was useful. Her understanding of midwifery is based on her perception of nursing and the nursing environment within the hospital and the opportunities gained within her nursing programme. She has clear expectations that a midwifery placement during her nursing programme will enable her to develop an insight into midwifery and what the midwife does. However when this does not occur, she expresses her disillusionment and disappointment at the minimal exposure to midwifery as a student, and questions her desire to become a midwife:

...the nursing was OK and my experience of midwifery as a student nurse was very minimal I had a three week placement and saw nothing so it didn't give me the impetus to think to go on and do this.

[Kirstie-midwife and mother of three children]

Following this disappointment, Kirstie describes her experience of working on a gynaecological unit, which offers her the insight of caring for women and women's reproductive health issues, which she did not have during her placement on her nursing programme. The relationship between gynaecological nursing and midwifery has been acknowledged. Bolton (2005:182) describes the gynaecological ward as an occupational culture, which 'relies on the ideology of the feminine as its distinguishing character.' Here

I suggest that Kirstie uses her experience to check out her interest in midwifery based upon her desire to care for women:

But when I first qualified where I worked [...] they had a unit which dealt with late terminations of pregnancy, it was a gynae unit, and women who also had problems conceiving, one extreme to another as well as women with gynae, quite severe gynae problems as well and at that point I thought about becoming a midwife, sort of initially post qualification and there was a nurse there who went on to do her midwifery training and I looked into all the bits and pieces she'd had, and I thought this is for me.

[Kirstie-midwife and mother of three children]

Working with a nurse who was also interested in midwifery enabled her to explore the possibility further which confirmed that for her. Drawing on her nursing experience, Trish also places some emphasis on her placement in obstetrics as an important influence:

I did my obstetrics secondment...that's what sort of drew me to midwifery and I have been with it ever since, you know,

[Trish-midwife and mother of three children]

Instead of gaining insight into midwifery she mentions 'my obstetrics' which reflects the terminology used for the placement which student nurses had as part of their General Nurse Training during the late seventies and eighties. This also reflects the influence of the medical model in which obstetrics is used rather than midwifery suggesting that in the nursing context, caring for women having babies is a medical experience rather than a physiological activity involving the midwife. To an extent this raises issues in relation to the problematisation of birth and childbearing within the confines of the hospital and how it is perceived within a nursing context.

Trish also suggests an instinctive attraction to midwifery, but emphasises the influence of nursing as the route into midwifery at the time:

I always wanted to be a midwife. When I say always, I have always wanted it from the time I was at reading stage I wanted to be a nurse and I remember getting a ladybird book about that...Florence Nightingale and the nurse [...] and then when I started, when I did my general training I then had a real interest in midwifery, you know, you do your obstetrics.

[Trish-midwife and mother of three children]

Describing this instinctive feeling of wanting to be a midwife is very difficult to define and to explain for Trish as it was for me too. Trish's account highlights two specific points, which are relevant here. Firstly I argue that the instinctive attraction to midwifery may reflect the essentialist notion of predetermined attributes of women to care for others around birth as considered in Chapter 1. There may also be the interconnection between embodiment and cultural expectation in relation to the practice and experiences of women. Secondly, Trish's reference to Florence Nightingale points to the influence of the

social construction of caring as a wholly female profession, in which the vocational nature and the self-sacrificing aspects of caring for the sick as typified in the construction and representation of famous nurses such as Florence Nightingale. The powerful image of the nurse in the Ladybird book and other children's books also symbolises the concept of care in relation to Florence Nightingale's identity as a woman and a carer and reflects the romanticised nature of caring reflected in books for children. Hallam (2000:10) supports the socially constructed gendered identity of the nurse here and states; 'Since Nightingale's day, nursing and female identity have been difficult to prise apart.'

Her reference to the Ladybird book also suggests that nursing, as a female activity where the sick are treated and made comfortable, is easily marketable to a younger audience. Midwifery with its association with sex is more difficult to advertise to younger audiences. I would suggest here that whilst nursing has a gendered public identity, midwifery does not have a distinct identity which is as marketable to a younger audience; therefore the identity of the midwife is inevitably linked to that of the nurse. The association between nursing and midwifery demonstrates the link between these two professions and the fact that the identity of the midwife based predominately in the hospital is very much associated with the image of the nurse. There is also an association here with the role of female helpers, which I discuss in Chapter 1 in relation to the identity of fictional characters such as Sairey Gamp.

Thus far I have established that for this group of eight midwives nursing played a significant role in their decision to pursue midwifery as a career. Whilst caring was considered to be an essential element of both professions, nursing was considered to provide the basic skills required. The identity of midwifery as a different profession is defined in terms of the need to check out what is it all about and the maternity /obstetric placement was considered to be the ideal opportunity for that. The close relationship between gynaecology and midwifery is made in relation to the concern about women's health although this is specific to Kirstie's experience. Whilst none of these midwives had personal experience of reproduction before they become midwives, two (Ann and Kirstie) become pregnant before the end of their midwifery programme. The next section will consider the influence of personal experience of reproduction and childbirth on midwives decision to become midwives.

CARING ASSOCIATED WITH PERSONAL EXPERIENCE

Midwives described their experiences of caring activities around pregnancy and birth as a major influence on their decision to become midwives. Unlike Ann, Chris, Grace, Jackie, Kirstie, Lucy and Trish, Anita described her decision to enter midwifery as influenced by her experience of caring for a female member of her family during a complicated pregnancy. Unlike the experiences of the midwives above, Anita did not want to pursue a career in midwifery following her placement as a student nurse at a time when she was learning to be a nurse:

I was nineteen I did my obstetric experience, which was part of my training at that point, and although I liked the theory, and I liked that part of it. I didn't like it at all it was very much... at that time people were being induced Monday to Friday, it was like a conveyor belt I found it...I was dissociated from everything, I wasn't emotional about anything, whereas a lot of the girls doing their training were uming and arring when the babies were born but I was totally unattached, I had no emotional pull. The only emotional pull I had was watching this poor mother... what used to happen was that a bell would ring and all the student midwives and nurses used to come across and stand in this small room with this poor woman...no husband, no companion just the midwife birthing her child...it was I stood there...absolutely dreadful, I felt like a voyeur, I shouldn't be there...and also my feelings were entirely for the mother, nothing to do with the baby but the fact that this mother was in pain and we were doing nothing about it and I thought at that time I am never going to be a midwife definitely not for me.

[Anita-midwife and mother of one child]

Her account of her experience on the labour ward at that time suggest the undignified way in which women were treated but also reflects the attitude that being emotionally detached was professionally desirable. As a registered nurse working in the community some years later, she compares how midwives in the community setting worked in contrast to the hospital midwives. Her account reflects her personal disappointment at the level of care provided for her relative and whilst she recognises the boundaries of her role as a nurse, identifies the deficiencies in the care provided. Through her relationship with the community midwives, she recognises the professional obligation within midwifery care and recognises that she has the skills to fulfil the role of the midwife:

I just came away from that thinking actually *I can do better than this*...this is just terrible and having seen my colleagues which I work with within the community setting as midwives and seen how they work was such a contrast to how the staff were and their attitude and the approach and I thought if I get the opportunity I will do my midwifery training.

[Anita- midwife and mother of one child]

Her account also illuminates the difference in the care provided between the hospital and community settings. Her experience of midwifery is influenced by the provision of community care, which focuses on the use of midwifery skills; communication, listening,

observation and assessment rather than technology and intervention. There is also a stark contrast between what she perceived to be the attitude of the midwives within the hospital compared to her observations of midwives within the community. Here we notice that she has developed an emotional connection, which enables her to assess the quality of the care provided in relation to her own professional standards as a nurse.

The personal experience of pregnancy and childbirth was also a key motivator for Alice and Susan, two of the midwives interviewed. Midwives within this study who completed a pre-registration programme were more likely to have commenced midwifery as a direct result of their experiences of pregnancy and birth. Alice describes in detail how her varied negative and positive experiences of pregnancy and birth, influenced her decision to enter midwifery:

I had all this wealth of experience of different sorts of birth and different experiences and I thought well I could perhaps help people to have nice experiences and even if their birth experience for whatever reason is bad, if it is a stillbirth or a termination for an abnormality, I know what they feel like because I have had that emotion from losing my own child and I could really be empathetic towards that women, hand on heart, and I could say 'I know how you feel.'

[Alice-midwife, mother of four children]

Two issues, clearly conveyed here, are emotion and empathy, which Alice clearly identifies as important attributes of the midwife and important features of the relationship between the midwife and mother around birth. Here Alice suggests that by drawing on her own experiences she has the ability to validate other women's experiences in similar situations. She recognises through her own experiences of birth and death, the emotional investment of midwives associated with providing midwifery care. Alice considers her experience to be of value to the role of the midwife and through this she considers empathy to be key to the role of the midwife. Hall (2001:60) in relation to empathy suggests that 'Empathy could also arise through...the bond of motherhood where the midwife has experienced birth.' However, it is also reasonable to suggest that as gender is central here that midwives can empathise with mothers because they could be in a similar situation in the future, even though they may not have children at the moment.

She sees the opportunity to enter midwifery as a way of being able to draw on her experiences to help others in similar situations. This may also be a strategy to enable mothers to validate their own experiences of reproduction and childbirth as an aspect of

their identity as midwives. Both Alice and Susan have a clear understanding of the midwife's role drawn from their experiences and the value of care as a key attribute is clearly articulated. Following the birth of her first child as a teenager, Susan was overwhelmed by the experience of pregnancy:

I remember sitting on the Postnatal ward thinking, gosh what a lovely job this was what a lovely ...cos I loved the whole pregnancy thing I really enjoyed it ...I did that and thoroughly got involved in it and then going into hospital and seeing what the midwives did. They went round and weigh the babies then, they used to do that then, and fed them, just little bits that happened, I thought this was a lovely job, never thought that I'd actually do it, because I was too busy with this young baby then...em and after she got a bit older, I just thought it was something I wanted to do, something I need to do, so I went into a nursing home just to get a bit of experience in dealing with other people, then I went to the hospital then I realized... then I decided....

[Susan-midwife and mother of two children]

When she describes the activities of the midwives on the ward in weighing the babies, she clearly identifies with that role which she describes as 'a lovely job'. Her decision to gain experience within the nursing home and then the hospital conveys a very structured approach to gain experience, which not only fits in with her family but also explore the deeper reality of working in a caring environment. This is in contrast to her earlier impression of the midwife's role. Susan like many of the other midwives considers the process of preparation before entering midwifery and unlike Alice, does not consider her experiences as a mother to be enough. She describes her efforts to gain experiences of working with people in a nursing environment as a way of checking out whether this was really what she wanted to do. Here too, Susan considers the usefulness of working with ill people as a way of preparing herself, although the context of care is essentially quite different. Moreover, I would argue that Susan's decision is more symbolic of her need to work within a caring environment, in which she gains some personal benefit from caring for others.

The desire to help others is a common motivator for those wanting to work as healthcare workers. However, the personal experience of negative or traumatic experiences could either result in unresolved issues, where midwives may find managing their own emotions difficult or they could fuel the need to help others through which they obtain some therapeutic effect from dwelling on their own experiences within a therapeutic environment. The concept of the 'wounded healer' (Nouwen 1977), may explain this phenomenon further in relation to the accounts of both Alice and Susan, although the implication of this concept merits further analysis. There is an assumption here that the

personal experience of physical or psychological trauma provides midwives, with a greater understanding of the situation, and as a result has a better ability to care. Developing an insight into the experiences of others may well benefit the relationship between the midwife and the mother. However what is important here is that whilst personal reflection is of value to the midwife, failure to resolve personal issues or divulging personal experiences inappropriately within the relationship with mothers, may have a negative affect on the relationship with the mother. It is also important to consider that midwives may limit their focus in some situations, which mirror their own experiences and this also has its limitations for the relationship with the mother. Secondly there is an assumption that midwives who do not consider themselves 'wounded' are unable to empathise and therefore may not be able to emotionally engage with mothers in their care. This is of course limited; the ability to empathise is developed through personal relationships in practice, experience as a midwife and the personal intuitive nature of the individual (Siddiqui 1999). A similar discussion in relation to the entry characteristics of pre-registration diploma students, reveals further evidence to support the presence of a similar concept of 'need to be needed' (Phillips 1997). Kevern, Ricketts and Webb (1999) draw on the work of Land (1993) and Phillips (1997), to suggest that nursing students had a greater number of recollected adverse life experiences compared to a comparable group of students outside the caring professions. The concept was reported to influence decisions to enter nursing, which was considered a therapeutic community, but was a predictive factor in occupational stress. Chamberlain (1996:120) takes this issue further in relation to student midwives on post-registration programmes, and suggests that negative experiences during their nursing career, may affect the student's response to her midwifery studies in which 'the student may enter her programme with unresolved conflict.'

Building relationships within a framework of continuity is clearly important to Tracey. She had always considered a career in healthcare but was unsure which profession to choose. The emphasis here is placed on the generic aspects of healthcare as a system that provides care to those that need assistance:

...I knew I wanted to be working with people promoting some kind of health issues...I think sort of the attraction for midwifery was the fact that you are quite independent and you know, you get on with it yourself and the fact that also you see everything through...

[Tracey-midwife non-mother]

She talks about the opportunities to see women through and provide care as an autonomous practitioner as a specific aspect of midwifery. Her emphasis here is placed on the midwife as a self-governing decision-maker outside the confines of the hospital. What is of particular interest here is her emphasis on developing relationships and she feels a personal sense of achievement when caring for women throughout the pregnancy and the childbearing continuum:

I like building relationships with people and I get my rewards from seeing their, you know, progress and so that was like, that was what I said in my interview for my place on the midwifery course, I get my rewards from being needed.

[Tracey-midwife and non-mother]

The notion of 'being needed' like the concept of the wounded healer discussed earlier is not uncommon in healthcare. Furthermore, some health professionals may consider care in relation to that which is provided by a parent for a child. This may include the protection from harm and the sense of trust. Phillips (1997) drawing on the work of Savva (1993) describes this phenomenon amongst healthcare professionals as 'parentification'. This in itself reflects the altruistic nature of caring and healthcare work. Although this concept has been described in relationships where the role of the parent and child has been reversed due to the parent's disability or ill health (Kelly et al., 2007), within the context of this discussion, I suggest that it may reflect the relationship between the midwife and the mother, where the midwife identifies the mother in her care as requiring additional support; caring in this context, may be interpreted as that provided by a parent or specifically a mother. However, this may challenge the dynamics of the relationship and may limit the experience of informed choice and shared-decision making. I consider this point further in Chapters 6 and 7 in relation to maternal identities and the provision of midwifery care.

MIDWIFERY, MOTHERHOOD AND THE CARE OF BABIES

Like many other women, midwives embarking on a career change or further training negotiate this change in identity in terms of the practicalities of fulfilling the new role in relation to their relationships and family commitments. Susan clearly considers this to be a major change in her life and makes that assessment in relation to the idea of having another baby:

...if I wanted to do it I would have to it sooner rather than later, and have another baby before...because otherwise there would be too much of a gap...then I had my second daughter...then decided let's get on with it. So went to the general got some experience did the access then came here.

Kirstie also having completed her nurse training describes her decision to start her midwifery training before she gets married and has children:

I already had it in the back of my mind for quite a while, but and I felt that I needed to get on with it and do it sooner rather than later, because I knew we were getting married in a couple of years and I thought if I left it, I would have to put it off until after we had children, which would probably be now...so I'm glad I did it when I did.

[Kirstie-midwife and mother of three children]

Kirstie reflects here on the appropriate time to further her career and become a midwife and considers this in relation to her aim of having children; in view of the fact that she is a mother of three children, she considers that she made the right decision as balancing both is difficult. In this context midwifery and motherhood are seen as competing identities in terms of the commitment required to fulfil the role of the midwife and that of a mother. This can also be considered in relation to the emotional investment required of both being a mother and being a midwife. Parallels can be drawn here behind the demands of home and work with the work of Acker (1980), who described the conflicting demands of home and university for female teachers and described the university as a 'greedy institution'.

The desire to care for babies is often stated as the reason for wishing to be a midwife but midwives spend very little time with babies and therefore, this demonstrates a limited understanding of the role of the midwife. Nevertheless the relationship between caring for babies and midwifery work is significant in terms of the essentialist notion of caring as instinctive and reflective of the mothering role. Demonstrating the ability to care was a significant motivation to enter midwifery for Julie and Rebecca. They both had previous experience of caring for babies as nursery nurses. Whilst Julie's tutor had highlighted midwifery to her as a career, she had little knowledge of midwifery at the time and had not necessarily shown much interest in it. As a pre-registration student she enjoyed the programme although she realised that her understanding of the role of the midwife was very limited when she began the programme:

I didn't really to be honest, know a lot about midwifery at the time, I was very naive about what midwifery involved.

[Julie-midwife and mother of two children]

In contrast, Rebecca considered midwifery as a more challenging career. Whilst her experience with babies was important she recognised that it would not be the only aspect of the midwife's role:

I think because I had an interest in the sort of childbirth process and everything. I worked with children at a nursery prior to my training but I felt that wasn't really challenging enough and I enjoyed working with women and being with women really...so I researched into it and it was just something that I really liked the idea of doing.

[Rebecca-midwife and non-mother]

Rebecca as a newly qualified midwife reflects an understanding of the woman-centred approach to midwifery care and reflects her personal philosophy of midwifery and working with women. This further confirms the notion of what Carolan and Hodnett (2007) define as a 'pro-femina' position in which there is an emphasis on women caring for women as discussed in Chapter 1.

This discussion has highlighted the way in which midwives are influenced by their own personal experiences of care around pregnancy and birth and the care of babies. The midwives described here have made specific connections between their experiences and the need to contribute to the care of other mothers and babies. Of interest here is the emotional significance of these experiences and the way in which the midwives utilise their experiences in practice, which will be discussed in the next chapter. Certainly what is evident is the underlying need of the individuals to give of themselves within the role of the midwife and formulate their experiences as a distinct feature of their identity.

LEARNING TO BECOME

Learning to be a midwife can be a very difficult process for students, and some have already suggested that the transition from nurse to midwife can be a personal challenge (Spence 2007). Within this discussion I focus on the issue of knowledge, which was particularly evident in the interviews of midwives who had recently qualified. Learning is a process of acquiring knowledge necessary to underpin midwifery care and is a major part of the socialisation process. Learning what and learning how were two significant aspects of the experience for three midwives within the study group. Tracey, Rebecca and Vicky had practiced as midwives for between four months and five years:

I think sometimes it can be difficult, you know, because when you just want to learn about something and someone keeps going over the same thing....

[Rebecca-midwife and non-mother]

Those of us without children used to get really annoyed because you know, we wanted to learn the professional way...but we felt, we often used to sit and moan that you know, all they ever do is present anecdotal evidence.

[Tracey-midwife and non-mother]

I suppose them having children, you could tell, they spoke about it and they, because it was relevant they would bring it up in conversation and at times you would sit back and think well I can't really contribute.

[Vicky-midwife and non-mother]

As non-mothers all three identified the tension in relation to the use of formal knowledge and experiential or embodied knowledge, in the development and use of knowledge in practice. For these midwives formal knowledge represented the official professional position taught in the classroom and was significant as a source of gaining competence. Whilst practitioners use multiple sources of knowledge in practice (Mantzoukas and Jasper 2008), the ability to do so is associated with experience and confidence. Here I suggest that student midwives without children feel disadvantaged at times and lack confidence which mothers may gain through the childbearing process. These students can only rely on textbooks to provide them with the necessary knowledge to fulfil their clinical skills and competencies in practice. However my interview data show that for some students who are mothers, significant personal experiences may be a key focus of recurrent conversations and therefore limit their ability to consider issues from a formal professional perspective. In addition this process of revisiting personal experiences may suggest the need to seek additional support to resolve personal issues. Both Tracey and Rebecca consider that the use of personal reflections and stories around birth interfered with their learning in the classroom, as they may not have felt able to contribute.

The use of personal experiences can be used well within more structured sessions if facilitated appropriately. Whilst all three accounts above reflect a sense of frustration, it is important to consider that story telling has been used within healthcare education as a means by which vicarious learning can take place (Ashworth 2004); that is the process of learning through peer's experiences (Roberts 2009). From these accounts it appears that facilitation could have been performed differently in order to focus discussion and stimulate learning.

Professional formal learning for all three midwives therefore was considered in the context as structured, fact-based and evidence-based information. Knowledge was authorized rather than experiential or reflective. Furthermore Tracey having completed a degree in an unrelated subject narrates the importance of evidence to support the development of professional knowledge. Her specific biography is significant, as she had experienced formal learning in which the emphasis on reflection was minimal. In her view students recounting their experiences relied on subjective, unsubstantiated and

unscientific information, although the way in which this experience acted as a trigger to learning is difficult to ascertain. Individual accounts of pregnancy and birth experiences were considered to detract from the formal professional learning or textbook learning that was considered to be the 'right way to learn' which students without children had to rely on. As junior midwives Tracey, Rebecca and Vicky reflect on the need to learn the right things in the right ways, for example the right way to perform procedures, promoting the idea that there was only one way. Their accounts suggest that students who were mothers were more inclined to use other sources of knowledge in combination with authorized knowledge. The emphasis on the right and wrong way highlights the emphasis on the professional label; being accountable and fulfilling the ethical principle of doing no harm.

Presenting information and giving advice as a student in practice, was a key issue in some of these accounts. Tracey questioned the balance between the use of experiential and personal knowledge, and the use of formal professional knowledge, in developing decision-making skills:

...I found that a couple of them sort of that worked in the same placements as me, I found other staff and even patients saying things like she is telling me what she did with her kids not necessarily what is right but then to me that raised issues of well what is right?

[Tracey-midwife non-mother]

However, the application of learning in consultation with women places much more of an emphasis on experience. Tracey having practised as a midwife realises that even the text may not offer all the answers. She recognises now the value of experience but considers the lack of personal experience of childbirth to be a limitation:

I can tell you what the textbooks say but I know that every baby is different and not every baby will follow the text book and so sort of I am learning on the job from other people's babies whereas I suppose if I had got my own children I would have learnt it from personal experiences so that has highlighted a weak area for me.

[Tracey-midwife and non-mother]

Tracey describes her learning to be very precise and prescriptive and to some extent she envies the others for having an additional source of knowledge to draw upon. Having had a few years experience she can now see the value experiential knowledge in combination with formal professional knowledge from the textbook, however she recognises that this knowledge will not be able to help her to understand every situation and that experience may support this aspect of learning:

...I think the girls that had got children were a lot more vocal than those of us that hadn't, I suppose because they had experienced childbirth and they had experienced babies whereas

the rest of us might have cuddled the odd baby but didn't know what it did to your body, what it did to your mind and then how it affected your life.

[Tracey-midwife and non-mother]

Students who were mothers were considered to be more vocal and opinionated and questioned the formal professional knowledge in the context of their own personal experiences. Rebecca also suggested that they had a different perspective because they were older and had more experience:

...the students that have got children have been quite a lot older so they have got a different kind of outlook on things anyway.

[Rebecca-midwife and non-mother]

The age of the students is also a significant aspect within this discussion. Although these three midwives qualified as midwives at different times, some of the students with children within all three groups were a few years older and had more life experiences including work experience and reproductive experience, to draw upon.

The experience of these three midwives highlight the tension which can occur as a result of poor facilitation of personal accounts of childbirth experiences as a trigger for learning. All three midwives depended on developing from knowledge to undertake the role of the midwife through formal professional means. However as Tracey reports, not all knowledge is available through formal teaching. The last part will focus further on the experiences of some midwives following registration.

BEING A MIDWIFE

In this discussion, I intend to introduce some of the ideas around the identity of a midwife at registration. Midwives constructed their identity from their understanding of their occupation basis in which they placed an emphasis on the practical aspects of the role, together with the understanding of the legal and ethical aspects of the professional status of being a midwife. Midwives recognised the aspects, which they could identify with their occupational group in relation to the culture of working and also the wider issues of regulation and supervision. Reference to training not only reflects the time at which they completed their midwifery programmes, but I would argue that midwifery is seen as a profession where training is required as activity leading to skilled behaviour. Practical knowledge is therefore supported by theoretical knowledge. Both Susan and Grace draw some symbolic significance to the issue of wearing a uniform within the hospital environment, which signifies their role as a midwife and their status as a registered

practitioner. Grace also considers the uniform in an historical context in which she associates midwifery within hospital with nursing and the public perception that everyone looks like nurses in uniform:

Well they call us nurse...Yes, it is just people associate those of us in a uniform as nurses and it is a very fine line and it rolls off the tongue easier than midwife, it doesn't sound friendly, if someone just called out midwife, I don't think it sounds as friendly, do you know what I mean?

[Grace-midwife and mother of two children]

Likewise midwives wear a similar if not an identical uniform in some hospitals thus representing a generic identity of the healthcare worker. For Susan the uniform represented her knowledge and the women's trust in her as a knowledgeable expert:

I'm not treated as a student with a different uniform on, I am treated as a midwife. And I do find the communication with midwives and mothers quite different to when I was a student and I'm sure about that you know it seems...that it seems that mums have a little bit more confidence in me which is down to wearing a different uniform.

[Susan-midwife and mother of two children]

This new status raises mothers' expectations and Susan accepts the fact that she should know more now as a midwife. She understands that there are parameters to the knowledge and the implications of poor knowledge. Susan also uses the word 'right' to describe the information given by the midwife and the repercussions of given inappropriate or inaccurate information. She understands the scope of professional practice and her duty to provide accurate information:

With mums as well because they think you're a midwife what you tell them is in a way sometimes what they believe is right whatever you say, they take that on board and they think that what you're telling them is right, it's got to be right, you can't afford to give somebody wrong information about something.

[Susan-midwife and mother of two children]

Midwives at the point of registration value the support and guidance of other midwives to negotiate their new identities and adapt to the cultural shift from the identity of the learner to that of a knowledgeable doer (Butler, Fraser and Murphy 2008). Kaviani and Stillwell (2000:219) define the system of preceptorship in which there is 'access to experienced and competent role model and a means of building a supportive one-to-one teaching and learning relationship'. As a recommendation from the Nursing and Midwifery Council (NMC) preceptorship is a framework, which provides support and guidance to midwives in their transition to midwifery practice. However, the presence and absence of the preceptor is visible in both Susan and Vicky's account. Whilst Susan appears to work within a structured system, she understands that the preceptor is not

always around to support her in practice and considers the fact that she has responsibility and accountability for the care she provides:

Going into work now I've got my preceptor ...she's not there when I'm giving out the drugs because I've got my own pin number now, and I know that I have the responsibility to know what I'm doing.

[Susan-midwife and mother of two children]

The importance of the pin number for Susan is a symbolic reminder of the legal and ethical accountability of the role and what it means to have her name entered onto the professional register.

Although Vicky 's account suggests that a structured programme of support is not in place, the fact that she worked in the same hospital after qualification enables her to seek support from senior midwives through informal means:

...so the transition from student to midwife wasn't too bad and the support from the sisters was good on labour ward and the other members of staff as well, the preceptorship programme wasn't very in place really.

[Vicky-midwife and non-mother]

The associated accountability that goes with registration is clearly demonstrated in Susan's description of dispensing Paracetamol. Susan describes issues of the preparation of midwives for autonomous practice:

Going from student to midwife and having...even if it's Paracetamol and working out actually if she can have it ...is a big thing...because normally I'll say she can have Paracetamol and I'll ask the midwife.... she can have Paracetamol can't she...it's not like that now. I've got the keys and I'll go to the drug cupboard and people will ask me things, to take phone calls...and I do all of that, I'm enjoying it and I do feel different it's a big deal now, but it was anyway, but I've really got to get everything right, I've got to make sure my record keeping is right. Because looking at me or my work and saying add this or I wouldn't of put or write it a different way I've got to make sure that what I write everyone can read, or somebody else can see that care has been given and the plan of care that is to carry on.

[Susan-midwife and mother of two children]

Her account illustrates the important aspects of her practice, which now reflects her professional status; carrying the keys is symbolic of her responsibility for keeping the drug trolley safe and locked; being asked questions and answering telephone calls reflect her knowledge and status amongst the other staff. One aspect, which she highlights, is record keeping. She recognises the importance of writing her notes accurately and legibly to reflect the care that she has provided. She suggests that the quality of her record keeping may reflect on her abilities as a midwife.

CONCLUSION

This chapter has raised a number of significant issues in relation to the construction of identity of a midwife. Whilst I have considered care, within the first part of this chapter, in relation to nursing, reproductive experience and childcare, the overarching identity, which emerges from the midwives' accounts is that of a caring professional. It is clear that midwives develop a sense of wanting to care in different ways motivated by different experiences. In the first part of this chapter the emphasis is placed on becoming a midwife, which is centred on instinctive and personal feelings of wanting to care which is developed either as a result of nursing experience or personal experience. In Chapter 1, I discussed the literature regarding the gendered nature of care work and that caring had become a part of 'engendering female identity' (Hallam 2000:14). In this context there is an acknowledgment that whilst care in relation to nursing and care work generally reflects an essentialist position, care as a concept around pregnancy and birth, reflects a specific eagerness to care for women which has some close links with gynaecology. However I have also highlighted the complex nature of the use of personal reproductive experiences in relationships with mothers as this can change the focus of the relationship from the mother to the midwife.

The identity of the midwife appears generally confused when the majority of midwifery services are provided from within the hospital setting. The distinction between the nurse and the midwife is less clear when the social construction of the female carer in a hospital setting is symbolised by a uniform. From the analysis of the data from the fourteen interviews, there did not appear to be a distinction between those midwives who were nurses and had been practising for a long time and those who completed a programme as direct entrants, in relation to the focus on woman-centred care. The socialisation of midwives through knowledge development was also an important point within the chapter especially in relation to prior experience of childbirth. The experience of midwives at the point of registration, highlights, the symbolic issues of professional practice derived from the historic relationship with nurses and reflect the institutionalisation of birth within the confines of the hospital. Accountability is a key issue within contemporary practice that demands high standards in relation to record keeping as a risk and quality assessment tool. Acknowledging the knowledge and

understanding of newly qualified midwives within the practice area reinforces their professional status. The next chapter develops this discussion further by focusing on the relevance of reproductive experiences for the construction of midwives' identities and the use of embodied experiences.

CHAPTER 5

REPRODUCTIVE IDENTITIES

INTRODUCTION

In the previous chapter I focused on the construction of the midwife's identity in relation to the development of a professional identity. Within that discussion I considered the influence of both nursing and reproductive experience on the construction of the midwife's identity as a caring professional. In this chapter I develop this further to explore how the experiences of reproduction shape midwives' reproductive and maternal identities.

Whilst motherhood has been described as both an ultimate fulfilment of womanhood and femininity, and a source of women's oppression, the midwives in this study saw motherhood as central to their identity as women. In this chapter I show that midwives' reproductive identities are complex and multi-layered, influenced by professional and personal knowledge and experiences. Since the majority of midwives interviewed became mothers following registration, I aim to illustrate that the occupational nature of midwifery and dominant professional identity influence their conceptualisations of birth and motherhood. Although the embodied experience of pregnancy, birth and motherhood is important to them in their relationship with mothers, I aim to illustrate through selective accounts that specific experiences of birth and early motherhood create conflicts that expose a fragmentation or disjuncture of the self in relation to the co-existence of identities. Against this background I show that the reproductive identities of midwives are potentially problematic; firstly in terms of their position as knowledgeable experts and secondly as mothers. I suggest that midwives who encounter difficult and challenging situations during their experiences of pregnancy and birth may find tensions between these competing identities.

This chapter is divided into four parts; in the first part I illustrate the experiences of pregnant midwives. This discussion considers the ways in which midwives negotiate transforming identities in relation to the physical and emotional demands of midwifery practice. The second part of the discussion illustrates the influence of midwives' expert knowledge of pregnancy and birth in relation to their own expectations of childbirth and transition to motherhood. Their use of knowledge and their insights into the maternity

services are considered here in relation to how they exercise agency and autonomy during childbirth and how this may be challenged. Also I explore possible explanations why some midwives reject the identity of 'expert', whilst others accept it. In the third part of this chapter, I consider how some midwives struggle to negotiate their dual identities and may choose to conceal their identity as midwives in some situations; others may consider this process of transformation as the loss of one identity in order to gain another. In the fourth and last part of this chapter, I concentrate on the ways in which midwives negotiate and renegotiate their identities in relation to motherhood and professional work. The accounts reflect ambivalence and uncertainty in relation to midwives experiences of childbirth and early motherhood.

THE PREGNANT MIDWIFE: A TRANSFORMING IDENTITY

The experience of working as a pregnant midwife raises significant issues in relation to how midwives develop their reproductive identities. For some midwives who continue to work during their pregnancies, their corporeal transformation within the workplace contributes towards the construction of their identities as mothers. The pregnancy projects a transient identity, in which midwives continue to work and fulfil their professional role, whilst embracing their transforming bodies and identities as mothers. This experience for many of the midwives interviewed encompassed the development of different relationships with colleagues but also reinforced a shared experience with mothers.

Jackie and Julie's accounts in relation to their first pregnancies, reflect the connectivity between some midwives, and also between them and mothers in their care:

Most of the people I worked with were fantastic, they were really caring and you know, looked after my bump like it was their bump....

[Jackie-midwife and mother of three children]

The 'bump' is a visual representation of the transition from midwife to mother, that signifies a transforming identity. The bump is evidence of biological reproduction and the changing shape and size of the midwife's body represents the process of normal development (Earle 2003). However, in both these accounts the bump is significant evidence of a shared state of identity between midwives and mothers and as such contributes to the relationship between them. In Jackie's account the relationship created from the visual appearance of a pregnancy, facilitates a supportive attitude amongst the midwives. Although there is recognition that the 'role' must still be fulfilled, the caring

nature of midwives creates a protective environment in which she feels safe and well looked after. In some cases, individual pregnancies can become shared ownership within a group; when the pregnancy occurs within a close female environment, the bump becomes the concern of all the women within that group. However Jackie's account reflects how special she felt within the comfortable midwifery environment, which represents a mothering and nurturing environment.

Julie's emphasis is on the relationship between her and the mothers rather than her colleagues. The bump in Julie's account also reflects the women's emphasis on a shared experience and a point of reference for discussion:

That was quite nice really because the patients, obviously when the bump appeared (laughs) the patients would be perhaps a bit more friendly, a bit more chatty. Just chatting to you about your own pregnancy as well as their own really.

[Julie-midwife and mother of two children]

The change in the attitude of women suggested here reflects this connectivity between women, which seems to break down informal barriers of communication. The changing nature of the midwife's body and the physiological effect of pregnancy symptoms such as nausea and increased tiredness, are also seen as a positive link between midwives and the mothers in their care. Both Kirstie and Lucy consider this to be an important aspect within their relationship with mothers. In Kirstie's account the experience of pregnancy is a shared experience in which the understanding of what is common and 'normal' is mutual for example:

...people take you quite well when you're a pregnant midwife, the mums do, they see you in the same boat as them... you feel probably as cheesed off and tired as they do which I think is helpful but no you feel completely shattered that's the only trouble.

[Kirstie-midwife and mother of three children]

At work Lucy maintains her identity as a midwife, enabling her to negotiate the physical symptoms of pregnancy such as nausea and vomiting, whilst caring for mothers:

...I was nauseous for nine months and vomited for nine months. But when I'm at work I would vomit and then come back and get on with things. When I'm home, I vomit and there's nothing to do, no one to talk to and I'm just sick all day (laughs).

[Lucy-midwife and mother of two children]

She finds working as a midwife during her first pregnancy a way of drawing attention away from her own feelings of being unwell:

...work for me was a diversionary sort of therapy, so it was good, and, you know, the women were made to feel a bit, well, chuffed, that 'a pregnant woman is looking after me, so she knows what I'm going through', you know, she knows...So, it did help me bond with the

women better and, you know, it helped with..., I don't know how to put it, just not feeling well, just feeling fat and sluggish and everything to do with just being pregnant really.

[Lucy-midwife and mother of two children]

In this way, work acts to reinforce the normality of pregnancy and its symptoms, providing a supportive environment in which Lucy can share her experience with midwives and mothers. Lucy also considers that mothers feel close to midwives who are pregnant, as they too are 'pregnant women' which indicates an acceptance of a shared identity. From Lucy's account, being pregnant at work gives her insight which helps her to establish a closer link with other mothers. Likewise, Rebecca recalls a time when she worked as a student midwife with a pregnant midwife whilst on a community placement:

Hard, definitely, she found she struggled because of the pressures of the job more than anything but I think she enjoyed it because you know, the women just loved it when she walked in, they went 'oh, you are pregnant too' and they would have something in common so that would like be an ice breaker so they often asked how many weeks she was, whether she was having a boy or a girl, things like that so yes, it was nice and I don't think she minded, she never ever complained about it.

[Rebecca-midwife and non-mother]

She describes how the midwife strived to fulfil her workload and the demands placed upon her as her pregnancy progressed and her pregnant body changed. Lucy also talks about the changing dynamics of the relationship between the pregnant midwife and the mother as a result of the presence of the midwife's pregnant body. The relationship here is centred on the mutual experience of pregnancy in which issues such as the sex of the baby is a feature of the conversations. However Lucy does intimate that mothers may become too inquisitive and ask too many questions, in which case the boundary between professional and private identity may be breached in her view. Whilst there is no suggestion of this here, pregnant midwives may develop strategies to maintain their 'public-facing working life' (Haynes 2008:638).

Whilst the discussion thus far has highlighted that the presence of the pregnant body may act to promote the relationship between pregnant midwives and mothers, it also creates a tension between the midwife's public and professional identity and her private personal identity as a woman in transition. The presence of a protective environment within the midwifery setting is accentuated in Jackie's account but is absent from Julie's, which suggests an inconsistent approach within the midwifery environment. This may be explained in the context of these accounts, by the working relationships between the midwives and the length of time the midwife has worked in the unit. However, what is

clear for all pregnant midwives is the corporeal reality of working during pregnancy in relation to the physical and emotional demands of fulfilling the midwifery role.

Physical demands of midwifery work

Some midwives described how they moved from one clinical area to another during their pregnancy due to the physical demands of the working environment. Working on labour ward during pregnancy can be physically exhausting because of the lifting and bending and due to the busyness of the environment. The size and shape of the pregnant body makes it difficult for the midwives to participate in the activities commonly associated with the role for example attending a water birth. As a result midwives describe their experiences of negotiating the care of mothers on the basis of their pregnant bodies and the physical activities associated with the role. Many referred to the fact that they were not allowed in theatre during early pregnancy. Protective practices such as relieving midwives from attending theatre, was a common practice twenty years ago, due to the alleged risk of miscarriage from exposure to anaesthetic gases (Grey 1989); this reflects midwives' concerns for other pregnant midwives rather than strict policy.

For Anita and Kirstie, the advancing pregnancy is considered as a physical barrier resulting in specific difficulties. Anita's account describes the physical difficulties in getting off the floor during a home birth:

I was at a home birth when I was 34 weeks I think and I was with my student ...she had a lovely lovely birth at home birthed on the floor on all fours it was lovely and I can remember I couldn't get up off the floor I just couldn't get up off the floor and I said 'I can't get up off the floor, you're going to have to help me. I don't know what's got into me' and she said 'Could it be that you're 32 weeks pregnant [...] that could have something to do with it.'... my last homebirth was when I was 36 weeks then and bless her I did feel guilty because there was no way I could birth her in an alternate position so she had to be on the bed although she was on her knees on the bed there was no way I could let her go where she wanted because I couldn't get down there to do so.

[Anita-midwife and mother of one child]

Her positive appraisal of this birth is contrasted by the guilt she feels some weeks later, when she is unable to offer the mother the choice of location to birth her baby due to the advancing size and shape of her own abdomen. Similarly, Kirstie describes how her advancing pregnancy prevents her from being involved in more technically difficult births on labour ward, since they are considered more labour intensive and more emotional because of the possibility of a poor outcome. As a student midwife her involvement is limited partly due to her status as a student but also due to her advancing pregnancy. She

identifies her involvement in births considered to be more straightforward and in areas where the work was considered to be 'lighter' in relation to the physical aspects, such as supporting mother's breastfeeding and help others by attending to the domestic chores of making tea and toast:

I remember being a student midwife and working on the labour ward at 34 weeks and I did deliver two or three babies but it was virtually impossible to get close the bed I never went into theatre for those weeks at all and spent a lot of time making toast and help with breastfeeding and remember sort of...walking around labour ward not doing a huge amount unless it was an easy delivery I never came into contact with anyone that had a difficult delivery and just biding my time really more than any thing else.

[Kirstie-midwife and mother of three children]

However Julie and Vicky suggest that there was an inconsistent approach. Midwives were not given any special dispensation for being pregnant and the work was undertaken irrespective of the pregnancy. Julie's account highlights her personal feelings as she was approaching her 34th week of pregnancy:

...they just didn't want to, they didn't sort of give you lighter work...The expectations for the work I think was just the same as if you were not pregnant...which I found disappointing towards the end.

[Julie-midwife and mother of two children]

...they weren't treated any differently really actually. They were expected to get on with it, I mean, they were nearly dropping them....

[Vicky-midwife and non-mother]

The timing of maternity leave in relation to the advancing pregnancy is key to explaining the difficulties which may arise as the changing size and shape of the pregnant body place additional physical demands on the midwife and as a result can affect the relationship with mothers. Whilst working practices have changed in the light of legislation in relation to maternity leave, maternity benefits, some midwives within this study continued to work well into the third trimester to maximise the time spent with their babies after the birth. For some midwives like Grace and Chris, the idea of working into the third trimester is problematic as the pregnant midwife is exposed to situations where negative or unexpected outcomes can be experienced and internalised in relation to their own pregnancies and forthcoming birth. Grace suggests that:

...the girls that are pregnant work too long into their pregnancy... I think they should leave a lot earlier than they do and I know why they are staying at work its because they have longer off afterwards but you can see sometimes the anxious look on their face if they have seen something or heard of something that is perhaps not a very good outcome or they have had a bit of a problem and they do look anxious.

[Grace-midwife and mother of two children]

Whilst both Grace and Chris recognise the financial demands placed on working women, Grace emphasises the physical and emotional demands of working in a highly demanding and emotionally stressful environment, where traumatic birth and unexpected stillbirths can stay with you for a long time. Chris concurs with Grace in relation to the length of time midwives spent in practice:

I think any woman does work too long now. I think they are all thinking that they can have more time afterwards and that will be more beneficial...some people can't wait to get back to work even if it is just for a few hours can they afterwards? But I think it, it must be difficult to work, you know, longer than, well some of them work to 36 weeks....

[Chris-midwife and mother of three children]

Midwives like Grace and Chris who birthed their babies nearly thirty years ago remind us that working practices have changed in the light of financial and domestic demands of childcare. Although they understand the reasons why midwives work longer they are aware of the increased anxiety and physical effort associated with midwifery work.

Kirstie considers her decision to take maternity leave in relation to her relationship with her children and the new baby. Spending time at home during the pregnancy when the children are in school is not seen as beneficial. Although Kirstie also described the process of working whilst pregnant as difficult and reflects the position held by Grace and Chris, in this context the working environment offers her the opportunity to continue in her professional role until she is required to care for her new baby:

It's hard being pregnant at work. But I wanted to keep going I felt that if I worked later with all of them, I would have more time to spent with them afterwards and the other children as well, and I felt that there was no point in leaving earlier because the others were at school....

[Kirstie-midwife and mother of three children]

Planning time with the new baby is a priority for Kirstie. Whilst her account also reflects her commitment to all her children, she sees the benefit in working late in order to have precious time with the new baby.

Whilst the physical demands of pregnancy for a midwife can be negotiated in relation to the working environment, the emotional stresses are harder to control.

The emotional context of midwifery work

The majority of midwives described situations where their midwifery colleagues were supportive during their pregnancies, embracing their changing identity and considered them as special. Midwives like Jackie and Julie recognised this as their special time, their

time to experience being pregnant and expected midwives who were 'doing midwifery' everyday to confer on them the same level of support as they gave other mothers:

...you did meet the odd one, you know, 'so you are pregnant, so, so?' you know, and I think it can be a bit like that for midwives, you know, if people are having a normal pregnancy and everything is fine I can see where they are coming from and they are confused you know 'why are they making a fuss?' but when it is your pregnancy and your friends enjoy your pregnancy so therefore yes, it is a special pregnancy and yes, all babies are special, you know, that is a bit of a cliché but when it is yours they are that little bit more special of course....

[Jackie-midwife and mother of three children]

Some were really quite funny about it, you know, they didn't give you as much support as I thought they would do, us being in this sort of job you would have thought, you know, they would have gone out their way to help and give you support but some I found were really the opposite....

[Julie-midwife and mother of two children]

Although the expectation of support as illustrated above is not surprising in this context, Jackie and Julie express their disappointment as to the lack of support offered by some colleagues. However, the midwifery environment is considered in the main to be a nurturing and caring space, where the pregnant midwife is protected from the emotional distress of the role, considered to be potentially harmful not only to her but also to the mothers she cares for. The accounts suggest that this is a negotiated space, where the pregnant midwife is protected either by moving her to work in other areas or by restricting her involvement in care:

I was advised that I didn't look after them because I was heavily pregnant it's not the best position to be in with a woman whose baby is dying...While I was heavily pregnant it was difficult... I wouldn't work with women who had babies who were terminal or they knew they were going to die. I didn't work with them. It wasn't fair being pregnant and have me look after them if we knew there was anyone coming in who hadn't felt their baby move for several days or they had a problem that ...of any severity which involved the baby not having a heart beat when they came in...I didn't see those women.

[Kirstie-midwife and mother of three children]

Kirstie -during her third pregnancy- worked on a pregnancy assessment unit where mothers with complicated pregnancies are seen on an outpatient basis. She details the fact that working in this area in the third trimester is not the most appropriate for pregnant midwives. This issue of segregation here is considered to be a protective act to reduce the potential harm to her of being involved in the care of a mother in which her baby may be dying, but also to protect the mother from the midwife, who in her pregnant form is representation of an ongoing positive pregnancy:

There was only one time that I felt awkward about being pregnant and that was with a lady who had a baby that died when I was first pregnant, she had a stillbirth and then...weeks

before I had Nigel she came through being just pregnant...she was quite shocked to see me pregnant ...and I felt it difficult to explain to her.

[Kirstie-midwife and mother of three children]

Here Kirstie reveals her guilt of being pregnant when faced by a mother who has a history of stillbirth. The feeling of guilt is a common emotion expressed by Kirstie and Jackie in relation to their work as pregnant midwives. Although Jackie had not planned her first pregnancy she describes the situation of moving off labour ward to work on the antenatal ward as it was considered to be the least stressful and heavy in terms of the physical demands. She says:

I came off labour ward to go onto antenatal because it was decided antenatal would be the least stressful, sorry, not stressful, least problematic with being pregnant because it is not so physical as being on the labour ward.

[Jackie-midwife and mother of three children]

However, even this move was not sufficient to reduce the emotional distress of working on the antenatal ward. In Chapter 2 I discussed emotion as a feature of midwifery care. Whilst there is an expectation that midwifery care will encompass a degree of emotional engagement and empathy, Hunter (2004a) illustrates that managing emotions can be more difficult for some midwives; this may be particularly difficult when pregnant. Jackie's account describes a very emotional experience of caring for a mother who has miscarried at the same gestation:

...we had a few mums that were in long term and we had one young girl who had had repeated miscarriages and was on bed rest and I think her pregnancy was at the same stage as mine and she miscarried and her baby must have been about, I should think about 18 weeks and that was surreal really because I obviously helped deliver this poor little baby and it was born, it wasn't born alive and dealing with all of that and I could feel my baby inside me and that was really weird, luckily I think we knew each other well enough for it not to be a problem for her and we did sort of have a hug and a cry together and I did feel very, I felt guilty actually, I did feel guilty that my baby was OK and hers wasn't and here she was having had, it must have been about her 5th or 6th pregnancy and no baby and here I was having an unplanned pregnancy, everything going OK and I did feel a bit guilty

[Jackie-midwife and mother of three children]

Feeling the fetal movements is evidence of her ongoing pregnancy. Jackie recognises that her presence is a representation of a positive pregnancy and acknowledges the possible distress caused by her presence on the antenatal ward. It could be argued here that whilst Jackie is distressed by the loss, her knowledge and experience as a midwife enables her to rationalise this experience in relation to her own pregnancy. Her move to the antenatal ward was a decision to lessen the physical and potential emotional stress,

although admissions to the antenatal ward are by their very nature complicated and vulnerable pregnancies.

During this first part of the chapter, I have discussed the physical and emotional demands placed on the pregnant working midwife. The occupational nature of midwifery draws the pregnant midwife and mother together, through a mutually shared identity. However, the professional and public identity of the midwife determines that she is exposed to the physical and emotional demands of working in a highly stressful environment. Although some negotiation can take place through the support of colleagues, some midwives choose to work later into the pregnancy to obtain the benefit of maternity leave. Whilst this may not reflect all midwives, as some like myself started maternity leave at 28 weeks, others may be forced to leave earlier due to obstetric or fetal reasons.

The ways in which experiences, such as Jackie's, affect midwives and their sense of selves as mothers is explored further in the next section. This discussion is placed in context of the choices and expectations they express in relation to their experiences of childbirth. I focus on the extent to which midwives draw on their professional identity as knowledgeable experts to facilitate experiences of labour and birth.

EXPERT KNOWLEDGE AND REPRODUCTIVE IDENTITY

Within the philosophy of woman-centred care, the emphasis on communication and knowledge is key to the relationship between the midwife and the mother, and the decisions made in relation to care. In this section I discuss the extent to which midwives used their authorized knowledge to support the decisions made. Here the data illustrate how midwives use their knowledge in quite different and challenging situations. The discussion begins by focusing on how midwives in this study articulated their expectations of labour and birth on the basis of their experience. This will be followed by illustrations of how they also exercised agency in light of their experiences and their anxieties.

Expectations

Both Lucy and Julie are clear about the type of birth they want:

Where I trained...at the time when I was there, they were very much into home birth, natural labour, that kind of thing and I thought 'if ever I have a baby, that's how I want it to be'. So, you know, I had my views about how I wanted my labour to pan out.

[Lucy-midwife and mother of two children]

I had high expectations of myself but on the other hand I didn't know whether I would be able to cope with what I saw the patients going through so it was really, I wanted really different, you know, I wanted it to be really good but then I felt could I cope with things that I had seen because you know...I just think the birth really, I was really desperate to have a normal delivery and you know, that was my main thing and would I be able to get through a normal birth, you know, initially without all the traumatic difficulties that some people end up having.

[Julie-midwife and mother of two children]

However many midwives discussed the ability to cope with the fears around birth. Julie is aware of the possible complications and difficulties which may arise, and her emphasis on her ability to cope is centered on her understanding of her own ability to give birth. Kirstie is also aware of her own ability to cope and here she focuses on her experience of working on the Special Care Baby Unit whilst she is pregnant with her first child:

The only experience during my pregnancy that did put me off a bit was when I worked in Special Care Baby Unit and dealing with very small babies and at the time I was there I was 26 weeks pregnant and the little babies used to frighten me because I felt that if my baby came then this is what I would be dealing with I found that I felt that I wouldn't be able to deal with that very well. And there were experiences during the pregnancy that did sort of frighten me a little bit about babies with abnormalities that had been delivered, babies that had died because you do come across things like that don't you, even as a student and they did worry me a bit but everything was going well with the pregnancy so it wasn't an issue....

[Kirstie-midwife and mother of three children]

The risk of premature birth and abnormalities is a great worry to her.

Promoting agency and autonomy

The key issue that emerges from the accounts of nine of the 14 midwives registered prior to becoming mothers is the extent to which they use their professional knowledge to facilitate a sense of agency and autonomy in the context of their personal experiences. Agency in this context refers to the way in which professional knowledge influences midwives' capacity to make free and clear choices about their care, whereas autonomy reflects the degree of control and responsibility midwives exert in relation to the choice and decisions made around childbirth. The main concern of some midwives like Julie was the potential need for intervention:

The induction, I just think it is a catalogue of intervention, I just didn't want any intervention at all from doctors or anybody unless it was absolutely necessary and it was, if it was going to be right from the beginning, you know, it was just a catalogue (laughs) of it sort of getting progressively more and more involved...Oh yes, I mean I have seen so many failed inductions and you know, people having to have syntocinon and sat on the bed and epidurals and that was just so far from what my idea of birth was because I'm very much into natural birth so the induction really for me, well I thought you know, an induction is the start of it all going totally wrong (laughs)...I had visions of having to have forceps and it just sort of spiralling out of my control really.

[Julie-midwife and mother of two children]

Whilst she establishes labour hours before the induction was due to take place with the birth of her first baby, her account illustrates her commitment to natural birth whilst still acknowledging the possible use of intervention if necessary. Her experience of caring for mothers who require induction demonstrates her knowledge of the problems which can occur when intervention takes place. Here she describes her resistance to the idea of induction, which she feels represents a medical approach to childbirth. She shares her belief and commitment to natural birth and raises the issue of control in relation to her ability to have a natural birth or her loss of control in relation to induction. Jackie is aware of the possibility of complications due to the presence of fibroids and as a result her decision to go into the unit early is based on her knowledge of the implications and consequences of labour:

I had gone in really when I felt I wasn't happy being at home, my contractions were getting uncomfortable, they weren't really painful but they were pretty uncomfortable, I did worry about being so far away from the unit and I know that is illogical but my 2 previous pregnancies, once I had got to second stage my second stage was very rapid and I was scared that if I got to that stage there was no way I was going to get to the hospital. I had been told I couldn't have a home delivery because I had got fibroids and a high head and so you know, so all these things go on in the back of your mind and you are thinking 'I don't really want to deliver at home just in case I haemorrhage and I will be a long way from the unit' so I was quite anxious really to get in....

[Jackie-midwife and mother of three children]

Both Trish and Ann reflect on their experiences of complications during pregnancy and birth:

...with all the problems I had during the pregnancy with him, I mean I knew that if my waters had gone early that that wasn't good and I was cross but they decided they hadn't gone in the end, you know, and they just sort of dismissed it, when that was indicated when I had the scan when they said 'oh yes your liquor volume is low' but then I suppose when I had that bleed, I suppose maybe then, that was the one time when I thought 'oh gosh, I wish I didn't know what I know because I think I could, you know, imagine all the problems that were going on with that bleed'....

[Trish-midwife and mother of three children]

Trish is disappointed that her own assessment of rupture of membranes was dismissed during the early part of her pregnancy only to be confirmed by ultrasound scan some weeks later. The implications of the low volume of amniotic fluid and the subsequent bleed, raises her awareness of the vulnerability of her pregnancy. To an extent, Trish realises the significance of the ultrasound findings during pregnancy and resigns herself to the possible outcomes. Although Trish did give birth to a live baby she is aware of the possible negative outcome related to the loss of amniotic fluid and bleeding:

I mean when my first one was born brow presentation typical posture head back and what have you, but my second one had a beautiful little head and I thought, 'Oh I could have delivered that' but at the same time I thought I am glad I had a section because I have seen some awful normal deliveries and I just thought I like things to be controlled. I have a section that's booked and everything is fine and the first time around I was so pleased that she found it was a brow presentation because I would have hated to have gone through labour and then to have an emergency section. Sometimes I feel I kind of missed out on a normal delivery but then I think well think about it seriously what is all that about, and I just think no thank God I am in this time where I can have a section because a hundred years or so ago I would have died and that would have been it.

[Ann-midwife and mother of two children]

Ann too reflects on her previous history of caesarean section. Whilst neither her or Trish has control over the outcome of their pregnancies, Ann too is aware that having the second caesarean section is the most appropriate form of delivery in respect of her previous history of caesarean section and considers this in relation to her own mortality. She rationalises the decision not to have had a trial of labour on the basis of her previous experience of witnessing '*awful normal deliveries*'. Normal birth in this context is considered as a state of being in control in which the mother assumes some physiological power over the birth. This supports Julie's and Lucy's position discussed earlier. If complications occur there is a sense of loss of control and the feeling of being out of control. In Ann's account, whilst a normal birth did not appear to be a realistic option, the caesarean section offers her the ability to maintain control and therefore constitutes a medically managed birth.

Grace describes the fear experienced during her first pregnancy in relation to the presence of high blood pressure:

The first pregnancy I had, I had high blood pressure, which was a little bit frightening because I actually was a midwife so I knew the risk factors of high blood pressure and I put on a lot of weight. I didn't enjoy being pregnant at all, I didn't feel happy about it,.... I think I was anxious, very anxious, I was convinced that I was going to have all the problems under the sun. Once I got into labour I thought I was going to have difficult labours, end up with caesarean section and all the other complications that go with it but I didn't.

[Grace-midwife and mother of two children]

Her account highlights that her knowledge as a midwife of the consequences of high blood pressure is central to her unhappiness. Likewise, when Lucy realises that the midwife is having difficulty in delivering the shoulders during her homebirth, the knowledge of the potential devastating consequences of shoulder dystocia instantly reminds her to move her leg and with the aid of her husband facilitates the birth of her son much to her relief. At this point Lucy describes the difficulty in separating her identities as mother and midwife:

The only thing I was worried about, my son was bigger than my daughter, and only at the point that it happened I worried because I had given birth on all fours and the midwife had trouble to get my son out and then it bothered me.... shoulder dystocia 'oh my god, my baby's going to die'. That's the only thing that bothered me, worried me but then I went back and I got my leg, I said to the husband 'hike my leg all the way back' ... Because I was thinking 'oh my god, how are we going to get this baby out, oh my god'. I think I was panicking as a midwife, not as a woman giving birth but as a midwife and I was thinking 'what would I have done being the community midwife who's delivering and I can't get this baby to come?' but as soon as I changed position and my husband had my leg back, the baby came. And I remember going 'phew he's here.'

[Lucy-midwife and mother of two children]

Her account describes how she assumed a distinct role within the birth, in which her clinical knowledge of the situation assisted her in adopting the most appropriate position. Her knowledge of the seriousness of the situation is so palpable that her instructions to her husband reflect the desperate nature of her actions to facilitate her baby's birth. Midwives' own expert knowledge operates in different ways here creating anxiety through their experience of problem births and making them more active participants like Lucy.

Exercising autonomy

Some midwives like Anita and Lucy were placed in situations where they drew heavily on their professional knowledge to achieve the births they requested. Anita after years of infertility finds herself pregnant in her forties. Having resigned herself to the position of being childless, she finds the impending role of being mother daunting. Her account reflects her determinism to achieve the birth she wants, driven by the obstetrician's position on intervention. As a senior midwife her dialogue with the consultant reveals some tensions in relation to her opposition to intervention and draws on her position and experience as a senior midwife to state her case. As she never thought she would have the opportunity to have a child, her assertive position reflects her need to maintain her plan for labour and birth; it is a mechanism to protect her decisions and to maintain control. Her resistance to the idea of being augmented after spontaneous rupture of membranes reflects her belief in normality and her own birthing ability, but also highlights her understanding of the complexity of induction and the role and consequences of intervention in labour:

...he (Consultant) was there and as we walked down I don't think the name clicked with who I was so when he saw me he went 'Oh hello' 'so you've managed to put a name to the face now have you.' So he said 'I've been waiting for you' 'Oh have you' I said 'that makes a change doesn't it.' So what do you want to do then and everyone was just aghast I thought this is dreadful you're all like he's just a person at the end of the day 'What are you intending to do?' 'I just want to check on position.' 'That's fine that's Ok I don't mind you

doing that if you feel a real necessity' so he did palpate me and that and 'as long as your not planning on doing a vaginal examination because I've already had one and I'm quite happy and the plan has been discussed and I know where we're going and what we're doing 'You should have started syntocinon' he said to me 'at 9 o'clock this morning' and I said 'No it was my decision I elected not to and it was worth a try and not putting anybody out or causing any problems labour ward isn't busy I'm not taking up any time and he's muttering under his breath as he went out he said 'she'll never do it with out an epidural anyway. We'll have an instrumental delivery midwives and nurses all have this'...really negative.

[Anita-midwife and mother of one child]

Likewise Lucy draws on her poor hospital experience during her first birth to rationalise her decision to have a homebirth:

If anything happens, I'm going to the other hospital.' I had the Matron on the phone to me saying that she knows she can't allow that and if something happens I need to come to the local unit. I said 'listen, I'm not silly, I'm a midwife and I'm a sensible person'. If there's a situation when the baby was in distress, if there was thick meconium then and there, I would come into the local unit because the other hospital is too far'. But if the same thing, like I'm not progressing or slow to progress, I will go to the other hospital.

[Lucy-midwife and mother of two children]

She qualifies her decisions in relation to potential complications by emphasising her position as a midwife. She highlights the fact that although she is determined to have a home birth she would not take unnecessary risks. Her use of the sentence 'listen, I'm not silly, I'm a midwife and I'm a sensible person' confirms the level of control she is determined to have over the location of birth. Her knowledge of the potential risks is also managed in relation to her commitment to a home birth as a mother. The benefits of home birth out way the dangers for her. Her reliance on her professional knowledge is clear in that she distinguishes between situations, which are of high risk with those, which are of medium to low risk. In this way she prioritises the potential use of the hospitals around her. In this situation Lucy illustrates how she uses her knowledge to support her decision to have a homebirth in conversation with the Matron.

In both these accounts, midwives rely on their professional knowledge to exercise agency and assume autonomy in relation to choices and decisions about intervention in labour and the location of birth. Unlike other mothers who may also develop knowledge to facilitate choices during their pregnancy, midwives' knowledge and understanding of clinical situations is different and influence midwives' expectations and decisions around birth. The use of formal and experiential knowledge in this way highlights the potential conflict, which could occur, when midwives like Lucy become aware of problems during labour or obstetric emergencies at birth. The process of negotiating identity as a professional and a mother can therefore be challenged when situations demand different

responses. However, the discussion in the next part of this chapter develops the aspect of negotiating identities further.

NEGOTIATING TRANSFORMING IDENTITIES

Here I focus on situations described by midwives where there was conflict between their identities as mothers and midwives. Underpinning this is the fact that some midwives found it difficult to cope with certain situations due to the perceived knowledge associated with the professional identity. In this part of the chapter I consider three specific situations that reflect the burden of professional knowledge for midwives who become mothers. I aim to demonstrate that over-reliance on professional knowledge can lead to inadequate care; on the other hand, conflict and tension can result, when this knowledge and the professional status of the role is not recognised and is overlooked. Likewise the associated status of this knowledge and professional identity, can act to segregate midwives from others in certain situations.

Ann describes her feelings following a caesarean section for her first baby:

I wasn't a midwife, I was a mother everything I had learnt had completely gone out the window. That surprised me...I felt I couldn't ask anybody anything, I should know, but I wanted to ask because I didn't know or I felt I didn't know at the time and of course you put a brave face on because your family comes round and of course well you know how to do all this don't you Ann because you are a... you know, you are a midwife dah, dah, dah, and some of the things just completely went out my head so yes, it perhaps was scary, I was fine when I got home, I felt I knew what I was doing and it seemed to me to be easy, I didn't have, yes she screamed an awful lot but it wasn't something that I couldn't cope with and everything was fine.

[Ann-midwife and mother of two children]

I use the word reluctant here, as Ann is reluctant to assume the identity of a mother where she may be required to ask for information and support from the midwives. She is also reluctant to relinquish her identity as the knowledgeable expert and accept the fact that she may not know everything and require help and support. Ann feels guilty and embarrassed about her lack of knowledge, and as she has 'learnt it', and as a midwife she should know. In this respect the expectation of always knowing what to do, is very unforgiving. Ann describes her feelings following a caesarean section for her first baby. In this context, this conflict between her identity as a midwife and that of a mother represents her reluctance to accept that she may need more information and support from the midwives. As a result the experience of caring for the baby during the first couple of days is unnecessarily stressful for Ann. In many of the accounts the immediate

postnatal recovery in hospital is considered as the most demanding when there are difficulties in the offer and request for help and support.

Whilst there is a respective acknowledgement of knowledge and status in situations like this, it could be argued that the midwives on the ward would also be considered to be reluctant in offering help, as they do not want to insult her knowledge:

I think they left me alone because they felt, I mean there is two sides to it really, I suppose they didn't want to come in and start saying do you know this, do you know that in case I get offended and I suppose the other side of it, they didn't want to, I don't know, I suppose they didn't want to make me feel silly maybe but I felt it would have been nice if somebody had said to me you are not going to know everything, you are a mother now not a midwife but I only know that because of my experiences.

[Ann-midwife and mother of two children]

As a result there is an assumption that as a midwife she will use her knowledge and clinical skills to an extent that she will alert the midwives on the ward if any problems arise. In this way the midwives are depending on Ann professional knowledge and skills to assess herself and her baby.

It was important for some midwives who were not in practice on a regular basis to be recognised as having expert knowledge. It could be argued here that due to changes in their work patterns, they had developed a dominant identity of mother. Trish's account highlights the difficulties encountered when the loss of a previously dominant identity is realised. Since the birth of her first child some three years earlier, Trish had worked as a midwife on the bank. Although Trish had not worked regularly as a midwife for many years, some of the midwives in the hospital where she had previously worked were unfamiliar to her, as she was to them. Since her pregnancy had been problematic in terms of early rupture of hind membranes at 22 weeks gestation and bleeding at 32 weeks, her baby was considered small for dates. Although the need for induction at 37 weeks had been a shock, she was aware that it was the appropriate decision; her baby weighed four pounds at birth:

They really treated me like a mum which in some ways is good because even though you are a midwife you still want to be treated like a mother, but on the other hand, you know, you want to have some credit for what you do know, but I knew that he was small for dates and what have you and he was.

[Trish-midwife and mother of three children]

As her baby required regular feeding and monitoring, she wanted to be recognized for her professional knowledge and her ability to care for her baby. Her sense of loss in this respect is also evident in her account of her labour where she feels unsupported by the

midwife, who was unfamiliar to her, who had not acknowledged her as a midwife. Whilst a midwifery colleague cared her for during her first pregnancy, she had not made any arrangements for her second pregnancy. Although her husband was present, she felt very unsupported by the midwife and disappointed by the care she received:

...but it was just awful, it was just, I didn't mind the induction, I just about coped with that I think it was from the time when they said 'Right we are going to break your waters now' and it was like, you know, this is your life in our hands, we are in charge now and there was no discussion and it was just like, and I felt, you know, and I felt I was in a privileged position because I was not only a midwife but I had worked there, but I hadn't worked with that particular midwife but I had actually worked there and I just thought this is, you know, this is awful.

[Trish-midwife and mother of three]

Trish was disappointed by the attitude of the midwife and whilst she had not worked in the maternity unit for a few years, she expected some recognition of the fact that she was a midwife and a previous member of staff. Her use of the phrase '*privileged position*' emphasizes her identity as a midwife and reinforces her continued membership to what she sees as an exclusive group of knowledgeable experts. She attaches specific status to this identity for which she expects some acknowledgement in terms of the discussion regarding care and her autonomy in relation to decision-making.

Whilst Trish clings onto the professional identity of the midwife, both Julie and Jackie describe situations where they had both experienced conflict in relation to their identity as a midwife. In Jackie's account of her second pregnancy, she describes her experience of hiding her identity as a midwife. Since she has been out of midwifery for about 10 years, she feels that her knowledge is out of date. She feels that care has moved on. In this way, failure to disclose her identity, is a means of protecting herself from professional attention and in this context the possible negative criticism associated with her lack of up to date knowledge. She considers that if her identity as a professional is known, her level of knowledge may be questioned and criticized and as a result she is protecting herself from the possible humiliation of realizing that she may not know as much she would be expected to know. In this situation the concealment enables her to maintain control as a pregnant woman:

They were practising team midwifery and I didn't, the whole of my pregnancy, that pregnancy I didn't tell anybody I was a midwife and had a very interesting view of care from the non professional viewpoint if you like...I think at that time I had been out of midwifery for, I have got to think now, I had certainly been out of contact with healthcare for 6 years and out of contact with midwifery for 10 so I suppose I felt you know, I hadn't kept up to date really and I think sometimes if, I just felt if I told people I was a midwife there would be an assumption that I knew everything and things had moved on quite a lot in 10 years

particularly things like antenatal screening and I just thought if I tell people I am a midwife they will just assume I know because you do get that, people assume that you know.

[Jackie-midwife and mother of three children]

In this sense, she is happy to relinquish her identity as a midwife in order to obtain all the information about the relevant aspects of pregnancy. Her reference to antenatal screening is particularly relevant here as the range of tests offered has dramatically changed over the last twenty years and continues to develop. She suggests here that to disclose her previous identity as a midwife would limit the amount of information received; this reflects the level of communication that occurs when assumptions about prior knowledge are made. By keeping quiet, she safeguards herself from being exposed as she openly accepts that her knowledge is not current. Also she ensures that she receives the information, which was crucial to her as a mother, which she felt she needed to ensure that she received the appropriate care. Her thirst for information is reflected by her reference to an experience she had during her first pregnancy, where she was denied the experience of attending parenthood education classes when she was working as a full time midwife:

...I remember when I had my first and I had him in the unit I was working in and I wasn't allowed to go to the parent craft lessons and they just said to me 'Jackie you can't come' because they were friends of mine and 'we will be too embarrassed, you can't come, you know it all anyway, what can we teach you?' and yes, OK, I did know it all but actually I missed out on a big chunk of meeting other women that were having their babies at the same time and I think probably that had something to do with it too so I think once you have gone down the road of not saying anything about being a midwife it is just easier to go along with the flow....

[Jackie-midwife and mother of three children]

Her need to develop relationships with other pregnant women non-midwives reflects her anxiety towards becoming a mother. Using knowledge of midwifery is adequate in some ways but she highlights the importance of gaining support from other pregnant women too. The emphasis here on knowing it all draws on the point I made in the previous chapter about the value of formal professional knowledge. In the context of Jackie's account there is a suggestion that midwives' knowledge is an expert source of truth that professionals possess. The implication here is that if this is the case it may challenge the philosophy of woman-centred care and deny women the opportunity to exercise autonomy within their decision-making.

The need to discuss issues of being a mother is also at the root of Julie's ambivalence. Both accounts focus on the issue of expert knowledge and the implication of that

knowledge in relation in their transition to motherhood and their practice as mothers. As a mother of two children, Julie feels ambivalent about joining a mother and toddler group following the birth of her first child because she felt that the other mothers would treat her differently on the basis of what she did as paid work, since her knowledge as a midwife gave her privileged status:

... I did actually find it very difficult joining mother and toddler groups because I didn't really want to tell them what I did as a job because I felt they looked on me different and I thought they would think 'oh, she's a 'know it all', we are not going to chat to her and we are not going to tell her all our fears and what is going wrong and they are not going to see me as what I would class as a normal mum because they thought I was... I don't know, not above them but I did find it very ...I just wanted to be treated as a normal mum because that is how I felt I was after I had the baby for the weeks, you know, the first few weeks and the first few months, really that is the end of our sort of midwifery even though I had done nursery nursing and 'nannying' but I just wanted to be treated as a normal mum and chat about all the fears and what was going wrong and what did they think about this and what did they think about that and I just didn't feel very comfortable with a lot of people in toddler groups and things and I felt they just viewed me differently.

[Julie-midwife and mother of two children]

She considers that the mothers will identify her as an expert and as a 'know it all.' However Julie recognises that as the midwife is only legally able to visit up to 42 days following birth, her professional knowledge after that point is limited; during most of Julie's experience this was the statutory length of time for which the midwife could legally care for a mother and baby before handing the care over to a Health Visitor. Although people in general believe that midwives spend time working with babies, in reality midwives spend most of their time in the care, education and surveillance of mothers with a view to ensuring a positive outcome. Whilst Julie was also a nanny, her account highlights her need for support and the opportunity to discuss the issues of adjustment and practical issues associated with becoming a mother, which concurs with Jackie's experience. Her need to be treated as a 'normal mum' reveals that she did not feel a normal mother, and whilst she may have had a range of expert knowledge, her need was to be viewed as a mother who in this instance had day-to-day knowledge and experience. Other mothers consider her professional identity as a midwife to be dominant, which sets her apart from the other mothers. Both Jackie and Julie acknowledge the need for support from other pregnant women and mothers, but recognise that disclosing their professional identity to both midwives in Jackie's case and to mothers in Julie's case, results in being considered as different.

Whilst I have illustrated that professional knowledge and expertise can aid midwives to exert control within their own decision-making, this discussion has highlighted that midwives within the hospital environment may find that disclosing their identity may either support their professional status or threaten it. A strategy used to lessen the personal embarrassment of not fulfilling the status is that of concealment, in which they preserve their identity as mothers but draw on their professional knowledge in secret. The presence of expert knowledge may alter others perception and attitude, to a point that the individual midwife may feel that the professional status alienates them from other mothers. Against this background, I reflect now on how midwives experience motherhood and make adjustments to negotiate the co-existence of identities as midwife and mother.

Motherhood as continuation

Motherhood is central to how the midwives interviewed within this study view themselves as women. It impacts on all women's perception of themselves whether they are mothers or not, but the practice of midwifery highlights this. As such motherhood is considered by the majority of midwives as a continued sense of self (Bailey 1999) although some midwives, as discussed earlier, experience situations where their identities as a mother and professional become fragmented when faced by challenging situations when professional identity conflicts with the identity of mother. Negotiating and renegotiating identity however can be a challenging experience which is illustrated in one midwife's experience.

Motherhood as ambivalent identity

Anita experienced great ambivalence in her transition to motherhood. The emotional context of her account reflects the reality of becoming a mother after years of infertility; she conceived unexpectedly at the age of 45. She describes the experience of not being able to cope with her daughter when she was one month old:

Once she hit one month of age my confidence seeped out quite a bit really I suddenly found I'd hit this barrier now what did I do now? Um I had quite a few days of feeling out of my depth and not feeling together about things at all and I'm sure she picked that up, because she wasn't very good either, bad nights, not settling all of this and my husband was back at work, you know, she had the colicky things and I felt I couldn't cope I did lose the plot I got very frustrated and very it was awful it was my first experience of losing the plot as I call it. I've lost the plot three times since I've had her.

[Anita-midwife and mother of one child]

Anita's reference to one month signifies the boundary at which she feels safe and confident within the identity as a professional. In the professional role she feels confident and as the expert she has knowledge, which promotes her sense of agency and autonomy. She describes it as:

..it's my comfort blanket it's my zone that I'm happy in. I'm good at it...I felt me in that. I felt right....

[Anita-midwife and mother of one child]

In this new role as mother, she says:

I was a bit out of my depth being a mother.

[Anita-midwife and mother of one child]

This is further defined by her lack of knowledge and her loss of expert status. Her emphasis on reading about child development and being a parent reflects her ambivalence and loss of control. This is new territory for her, which is challenging:

I'm reading about child development and that was important to me... how to be a parent that was my worrying bit so I was more focused on that than I was on the rest... I think I felt very confident all the way through really pregnancy birth and the first month because that was my field of expertise....

[Anita-midwife and mother of one child]

Following her reluctance to accept motherhood as evidenced by her detachment and concealment of her pregnancy from most of her colleagues, her initial transition to motherhood continues to be marked by detachment. Guilt is an emotion that is articulated throughout Anita's reflections of her transition to motherhood; and feels now that she really did not bond with her child until she was over 2 years old. She explains how guilty she feels about going back to work earlier than others would have expected her to, but she finds motherhood difficult and her work is an important part of her life:

...it only kicked in when she was 2½ years old that I really accepted that I was a mother. Whether its years of conditioning and I never expected to become a mother never ever and then I suddenly was, and all the responsibility and everything that goes with it. Yes maybe as she's got older.I just..she's a little sausage at the moment but I love her to bits absolutely wonderful...Work is still very important to me. I'm hopefully just getting my priorities in order....

[Anita-midwife and mother of one child]

Renegotiating identities after years of assuming a dominant one is a way Anita can minimise tensions between her identity as mother and midwife. Returning to work enables her to maintain normality and sense of self. Haynes (2008:633) drawing on the work of Alvesson and Willmott (2002) suggests that 'when a familiar identity, associated

with the sense of “being oneself”, is unsettled, feelings of tension, anxiety, guilt or shame arise.’

Promoting dual identities

The majority of the midwives who had become mothers following registration as midwives, had made adjustments to negotiate their identity positions and promote their co-existence through changes in their work patterns. A number of midwives like Trish, Jackie, Grace and Chris, described how they had stayed at home after the birth of their first child and did not return to work until after their youngest child was about one year old or had started school:

...I had 2 years off between my first and, I didn't work between my 2 pregnancies at all and I came back to work after my youngest was about a year old, very, very part time, only the twilight and I felt my first priority at that point was my children and my family and my home and that is what I was enjoying and I do say to these girls, enjoy your baby, just keep coming back just to keep ticking over so that then it is not such a big culture shock when you do decide to come back in 2 or 3 years time because that is what I found after being out of it for nearly 3 years, about 2 ½ to 3 years, was coming back into midwifery and so much had changed even in that short space of time and if I had kept a couple of hours a week ticking over it is not such a cultural shock.

[Grace-midwife and mother of two children]

Others like Lucy, Anita, Ann, Julie and Kirstie, drew on additional childcare arrangements such as family, nannies and formal nursery care to support their return. Support and to an extent financial stability was a key feature to how they negotiated childcare, experienced motherhood and continued to work as midwives. Having returned to midwifery, Jackie describes the enjoyment of working when her husband is available to look after her youngest son, but reinforces the difficulties of balancing work and picking her son up from school:

I mean like Saturday I was working and my lady delivered at half past 9 and I obviously I stayed for it, I mean I could have gone at quarter past 9 and if I had to have needed to go then I would have gone but because it was a Saturday and my husband was here looking after the children I knew I could stay and be relaxed in that so I didn't get home until 10 past 11 but it didn't matter and that was lovely because it wasn't intentional and I wasn't being drawn but when I do an early, it is like on Wednesday I am on an early, my son finishes school at half past 3, I can only ...I have to be there, I can't stay on for a long time but yes it is, it varies.

[Jackie-midwife and mother of three children]

The commitment to picking up her son reflects the importance placed on being a mother and the practical responsibilities of having children. Although Kirstie explains how negotiating her identities enable her to continue to work as a midwife and the importance of the working identity for her, her commitment to relinquish her identity as

a midwife is considered as appropriate to reduce the negative effect on the relationship with her children. In this context her readiness is seen as a self-sacrificing act:

I really enjoy my job I've worked hard to get to do what I do and I would be disappointed if I had to stop and let it go but if things came up with the children that meant I had to leave work then I would leave work I wouldn't hesitate but working does jeopardise the relationship I have with the children and in parts they get time without me as well as with me and I suspect that the time they have without me they get they do lots of things they go out to play areas they get to make a mess and when mummy gets home and it's 'Oh God what a mess' [laughing] I think they get some time with me and a bit of time without me and then my husband is around at the weekend we get time as a family, because I don't work many weekends at all so...em...but I do love my job.

[Kirstie-midwife and mother of three children]

However, for Kirstie, promoting dual identities is a challenging experience. Whilst she enjoys her work, she uses the word 'jeopardise' to describe how work can interfere with her relationship with her children and, thus, her identity as a mother. Alice experienced motherhood as a teenager and became a midwife once her identity as a mother was firmly established. After qualifying as a midwife, Alice chose to become a foster parent:

...I just felt that I wanted to do something else, I didn't, although midwifery was very satisfying, I just decided that being a foster parent might be another option for the caring role that I could do so that is why I went into it...I want to show the girls, I primarily have girls, sometimes boys but mostly it is disturbed young teenagers from 12 upwards that I have or the ones that are actually leaving care and as I have had struggles myself as a single mum and the majority of my children's lives have been just with me because you know, the fathers have been absent, to show them that being a single mum doesn't have to mean that you have to let,...I could have turned to drink or drugs or whatever and just been on benefits and sunk but I didn't, I chose to swim...however hard things have been for me and my children we have always been together and none of them have had to go into care of be separated apart from the hospital ..escapade but you know, to show them that as long as you have got love and the nurturing side then you will keep your children and you can go on to have quite a successful happy life.

[Alice-midwife and mother of four children]

Alice's account indicates that the dual identities of mother and midwife can be subject to change and negotiation. She became a mother early in her life and then developed a career as a midwife. Seeking to extend her caring role in the context of her life experiences, she then chose to foster disadvantaged children as a way of reinforcing the value of the family and her role as a mother.

Infertility as a threat

The extent to which infertility is considered a threat depends on where a woman is in relation to her reproductive life. Three of the women in the study group of midwives were non-mothers (Rebecca, Tracey and Vicky). Whilst all expressed a strong desire to be

mothers, Rebecca is particularly concerned about the implication of infertility for her work as a midwife and is the focus of the discussion here.

Rebecca, a married and recently qualified midwife in her early twenties, is fearful of the possibility that she may be infertile. She talks at length about her desire to have a baby but is aware that the ability to conceive may be 'out of her control'. She draws on her knowledge of conception to highlight the complexity of conception and the fact that her knowledge has to a certain extent enabled her to have some control over the 'best time' to conceive:

I think people take it for granted when they don't know anything but oh yes, you just get pregnant because I suppose I was a little bit like that before I started my training that you know, you just think 'oh, I will get married, have a baby and it will all be fine' you don't realise that (laughs) things can go wrong and you know. I think it is things like knowing there is only 3 days of the month you can get pregnant (laughs) and things like that which you might not have known if you didn't have that sort of knowledge so it puts a lot of pressure on you (laughs).

[Rebecca-midwife and non-mother]

However, whilst this knowledge is useful to her, she takes on board the responsibility that comes with it as a midwife and as a woman. Her knowledge is a threat to her potential identity as a mother since her professional knowledge informs her of the reality of infertility and enables her to assess the future possibilities of becoming a mother:

...I keep saying you shouldn't worry about it and it will happen but because I see people that you know, have taken years and years to have a baby and I think 'oh, I don't think I can wait years and years and go through all the things that they go through' and then be working. I think that is the biggest thing because people say 'oh well, you need to try and forget about having a baby and it will happen and when it will happen' and it is like but I work every single day with women that are having babies, it is not like I work in an office where I don't see one baby, you know, I see lots of babies and mums and things so it is hard not to have that on your mind all the time

[Rebecca-midwife and non-mother]

Rebecca is also very aware of the effect of infertility on her role as a midwife and reflects on her experiences of watching other midwives dealing with infertility. Like Rebecca, many midwives within the study described situations where midwives who had difficulty in conceiving had left the profession, as they were unable to work with pregnant women. The comparison with working in an office highlights the fact that the maternity environment in which she works is a constant reminder of her own lack of reproductive identity:

I just think, I don't think I could do the job if I couldn't have children, I have already thought about that because I think it would just be, I just don't know how I would do the job....

[Rebecca-midwife and non-mother]

Being a mother is central is how Rebecca perceives her professional identity as a midwife, without motherhood she would consider it impossible to continue as a midwife. She qualifies her position by contrasting the role of the midwife with that of a mother in relation to knowledge and experience of childcare:

...there is an expectation as well, you know, you should be this model parent really because you know what you are doing but it is very different talking about and having the theory than actually having a baby yourself and you have got this baby and all the emotions and everything that you have got to deal with, it crying in the night and, because if we advise women all day and every day about things and baby care and health and hygiene but I can imagine it would be so different having a baby 24 hours a day at home...(laughs).

(Rebecca-midwife and non-mother)

Within this discussion, I have illustrated that midwives have described various positions in relation to motherhood including ambivalence, uncertainty and acceptance of motherhood as a natural state. What is clear is that some midwives consider the identities of the midwife and mother as inseparable and as result the threat of fertility challenges their identity as a midwife.

CONCLUSION

In this chapter I have illustrated that midwives negotiate their identities to maintain the interconnected dual identities of both midwife and mother. This process starts during pregnancy when the pregnant midwife negotiates her public professional identity and her personal private self in response to the mutually shared identity with mothers. Although this can be potentially problematic, midwives emphasise the positive nature of their transforming identity in terms of their relationships with colleagues and mothers. However central to the understanding of identity in relation to this group of women is their gender and the social expectations of the work that they do and the environment in which they work in. The presence of professional knowledge underpins the process of negotiation undertaken by many of the midwives within this study. Whilst for some midwives professional knowledge was used to support decision-making and therefore disclosure of their identity was considered to be positive and empowering, for others the presence of professional knowledge created conflict which resulted in concealment of professional identity. Since professional identity is characterised by the presence of expert knowledge when this is absent, lacking or privileged, midwives recognise the limited value of their identity and prefer to discount this identity for fear of criticism or rejection.

The majority of midwives within this study considered that motherhood was a continuation of the self, rather than a separate self; these identities were therefore intertwined. Midwives wanted to be considered as professionals as well as mothers and to be respected for possessing the knowledge and expertise associated with it. However, whilst for the majority of the time these identities co-existed in a harmonious way, some midwives negotiated the maintenance of a dual identity, especially when motherhood was unexpected. Ambivalence in relation to motherhood was particular to the experience of older motherhood and to the possibility of non-motherhood, in which tensions between their professional role and identity as mother was created. Midwives within this study maintained their professional identity by negotiating changing work patterns and additional child care arrangements on their return to work. It is suggested that for some midwives, the presence of a professional identity offered them a greater sense of agency than experienced by other non-professional mothers, whilst for others it was a burden to be concealed.

Here I argue that the strong association between midwifery and motherhood as continued co-constitutive identities is explained by their occupation as midwives, in which reproduction and birth are central and the sense that care and support is reflected in their identities as mothers. The extent to which the identity of being a mother shapes the identity of a midwife will be one aspect examined in the next chapter entitled 'The Good Midwife.' As a means of addressing the effect of the embodied experiences within midwifery practice, the focus of this chapter will include the accounts of both midwives and mothers.

CHAPTER 6

THE 'GOOD MIDWIFE' AND 'OTHER' IDENTITIES

INTRODUCTION

In Chapter 4, I established the identity of the midwife as a caring professional and demonstrated in the last chapter that midwives negotiate and renegotiate their identities of midwife and mother in different ways. The focus of this chapter will continue this discussion and focus on how the embodied experience of reproduction and motherhood shape midwives' identities further. For this reason, I examine the construction and representation of the 'Good Midwife' as described by both midwives and mothers, as a distinct identity that embodies the identity of the caring professional. I use the relationship between midwives and the mothers in their care to explore how mothers are part of this social process of making and remaking the 'Good Midwife'.

Within the first part of this chapter, I emphasise the professional aspects of the identity of the 'Good Midwife', together with the association between the 'Good Midwife' and mothering. Both midwives and mothers acknowledge the identity of the 'Good Midwife' but professional and social constructions of this identity vary between and within the study groups. In the second part of this chapter, I draw on the concept of 'Othering' as a relational rather than an exclusionary concept to construct an opposing identity. The construction of identities of midwives considered as 'not as good' are deemed as 'Others' and contradict the identity of the midwife as a caring professional established in Chapter 4. Both study groups of midwives and mothers describe some midwives who are not 'good' as 'horrible', 'terrible', or 'rude'. It is not my intention to represent the identity of 'Others' in this context as a deviant identity, although Furber and Thomson (2006), in their study of breastfeeding practice, acknowledge that midwives who do not practise in accordance with baby-friendly policies, may display deviant behaviours. Furber and Thomson (2006), emphasise the fact that 'rule-breaking behaviour' can be negligent. However, in this context, I suggest that the identities of 'Others' are constructed in terms of difference; I show that midwives who are given the opportunity to select a midwife to care for them in labour participate in what Johnson et al., (2004:256) describe as 'Othering practices'. Midwives develop their own identities in contrast to 'Others', whilst mothers construct the identities of 'Others' in relation to their expectations of midwives

and how they think they should behave. Although the focus within this thesis has been placed on the relationship between women, I asked mothers during the interviews to consider the issue of the male midwife. For this reason, I extend the discussion to consider the identity of the male midwife as 'Other' in order to explore the gendered nature of midwifery, reproduction and identity. Whilst none of the mothers interviewed had any contact with a male midwife, this discussion considers some of the issues raised from their perspectives.

DEFINING THE 'GOOD MIDWIFE'

In the context of contemporary healthcare, expectations of quality services and high standards of care demand that each practitioner has attained the minimal competence level to register; this underlines the importance of upholding professional codes and standards of professional practice (NMC 2004; NMC 2008b). By notifying her intention to practise, each midwife on a yearly basis declares her fitness to practise and by doing so deems herself competent. Whilst it may be commonplace to associate 'good' with 'competent', the definition of the 'Good Midwife' is harder to determine. In their review, Nicholls and Webb (2006) conclude that the good midwife is perceived to have more than technical skills. They suggest that 'some midwives have a value-added factor, meaning that they are good as well as competent' (Nicholls and Webb 2006:65). Attributes such as good communication skills, being kind and caring are considered to be key features, and they conclude that being a good midwife is therefore different from being a competent midwife. My focus is not on the issue of competence, but it appears worth noting that competence refers to the performance of skills at an appropriate level that is assessed against clear, observable and measurable outcomes (Nicholls and Webb 2006). My research explores the phenomenology of the 'Good Midwife' as perceived and constructed in the lived experiences of both midwives and mothers.

Both midwives and mothers within this research articulated specific expectations of what a midwife should be and how she should behave, which go beyond the completion of skills related to competence. It is useful at this point to review the definition of the midwife in the context of the discussion:

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 practise 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 newborn 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 the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

(International Confederation of Midwives Council 2005)

The emphasis in this definition is on competence and the scope of practice that underlines the professional obligations of the midwife. This definition does not encompass the positive personal attributes such as being friendly, non-judgemental, attentive and nurturing, which some researchers associate with the midwife (Halldorsdottir and Karlsdottir 1996). I suggest that some of these expectations are socially constructed in relation to traditional images of female caregivers within hospitals and women workers in general, and as a result the identity of the midwife is rather confused at times.

The social construction of the identity of the 'Good Midwife' is therefore complex, since it raises moral, ethical and professional questions in relation to safety, competence and appropriateness for professional status. If we accept that there is a specific identity of a 'Good Midwife' then it is reasonable to suggest that there are differences between a midwife and a 'good midwife.' Like Nicholls and Webb (2006) I do not suggest here that there are 'bad midwives', although questions in relation to the suitability of midwives to practise are made in relation to lack of competence, ill health or misconduct, and are duly referred to The Fitness to Practise (FtP) Directorate at the Nursing and Midwifery Council. If the identity of the 'Good Midwife' is therefore constructed as a relational identity, the way in which the midwife builds and maintains relationships with women in her care will reflect on her identity and the value placed by the woman on the nature of that relationship. In the following discussion I draw on the experiences of midwives to explore their conceptualisations of the 'Good Midwife.'

CONCEPTUALISATIONS OF THE 'GOOD MIDWIFE'

Choosing a midwife to care for you in labour could be considered a privilege that some midwives in this study experienced. Midwives are often given the opportunity to select the midwife or midwives they wish to care for them in labour, especially if they have worked in a maternity unit for a long time and developed personal and professional friendships. Whilst this practice may not be common in all maternity units, some midwives may make arrangements with colleagues well in advance of the birth. When midwives recount their experiences of working and being cared for by fellow midwives, they emphasise the importance of those midwives who share similar and different qualities to them. As discussed in Chapter 1, I suggest that this is a practice of 'saming' and 'othering' (Weis 1995) which midwives use to develop and consolidate their own identities. Midwives who identified with similar colleagues described them as 'great', 'lovely' and 'good' whilst 'Others' were described as 'horrible' or 'rude.'

Midwives within this study had clear ideas of the midwives they wanted to care for them. As a previous teenage mother and now a newly qualified midwife, Susan describes her feelings about the possibility of having another baby at the maternity unit where she now works as a midwife:

...there would be quite a few I would be happy to look after me, some I'd think oh I'd rather she didn't... The ones, which I look at and I think well you're a good midwife, are the ones that are empowering, of other midwives and women and believe in normality and are not quick to put the CTG on and all that stuff that we are trying to get rid of, and I think we are really. But I think the ones mainly are empowering and I haven't always seen them in practice but I like what they talk about, I like the way they are their friendly, happy, the ones that look like they 're enjoying what they doing not the ones that roll in and say 'Oh God back again' and I think 'Oh dear' and they're the ones I certainly wouldn't want to look after me or my daughters....

[Susan-midwife and mother of two children]

Her emphasis on the importance of empowering women reflects her own experiences of disempowerment and loss of control when her second child was born, which she describes as a 'horrendous' experience. Her experience as a midwife has now given her insight; she identifies with some midwives who do not rely on technology too readily, those who use their skills of assessment and knowledge of normal physiology; midwives who display a positive enjoyment of their work:

...although the ones that are empowering are usually older as well, the ones that know their stuff and you know, that's what I aspire to. The ones that are really...good at their jobs, and they always do the right thing, their record keeping is really up to scratch, the way in which they write their notes is brilliant, it's all neat and tidy they're really professional. And

just...you know without being bolshie they really they're quite happy to express the way they feel about things.

[Susan-midwife and mother of two children]

These midwives are positive role models for newly qualified midwives like Susan. The 'Good Midwife' as described by Susan is also empowering. Kirkham (1999:738) suggests; 'If midwifery practice is to empower women then midwives must experience empowerment themselves. This is hindered by a disempowering culture.' Susan describes the 'Good Midwife' as one who is able to argue her case and displays a degree of autonomy without resorting to being 'bolshie'. The use of the word 'bolshie' in this context highlights the extremes to which midwives may go to maintain their autonomous position within practice. The identity of the midwife illustrated here is one which is potentially rebellious and stubborn, unwilling to yield or conform. This resonates with Russell's (2007) work referred to earlier in Chapter 1, in which midwives described as 'bolshie' or 'mad' were seen to exert their autonomy within the obstetric environment of the labour ward. In the context of Russell's work I suggest that the findings of her study are another illustration of 'Othering' associated with the stereotyping and marginalisation of midwives who maintain a more 'with women' rather than 'with institution' (Hunter 2004a) approach to care. I suggest that a refusal to conform is a key attribute here in which the 'Good Midwife' does not feel obliged to agree with senior colleagues or accept their decisions but is confident in their philosophy of care and the competence of their practise. The professionalism associated with this account reflects Susan's respect for this midwife who epitomises the identity of the 'Good Midwife', which she upholds.

The 'Good Midwife' is also considered as one who is supportive but also a good decision maker. Rebecca, as a newly qualified midwife without children values the possibility of friends and colleagues around birth but also considers the importance of the midwife's experience:

...it is funny because as I have got friends from the course and they have qualified they have often said 'oh yes, I would like to look after you' and I have thought 'oh, that is quite nice' but then I suppose at the back of my mind I still think 'oh, I would quite like someone experienced as well to be there' so I think experience is important but also just someone friendly and I have got a couple of people that I know and even though I know them really well that doesn't really bother me too much as long as they are nice.

[Rebecca-midwife and non-mother]

As a newly qualified midwife her emphasis is placed not only on support from newly qualified midwifery colleagues but the combination of support with experience. For her it

is important that the midwife can also make the appropriate clinical decisions, which she associates with experience.

Midwives also identified aspects of their own identity and professional practice with other colleagues. Having practised midwifery for a number of years, both Julie and Anita describe their experiences of being able to choose the midwife who cared for them in labour. Julie describes what happened during her first pregnancy:

...I didn't actually choose the midwife, no. The pool was obviously in the hospital, I had the birth in the hospital, it was only when I got there and I was in labour that they just gave me a selection of the midwives who were on duty and said which one of them would you want...so I managed to choose a midwife that I had worked with before in my team and who was very authoritative, very good at decision making, very firm but also very much into natural birth, natural birth which I think was a wonderful balance because I think if anything had gone wrong or if I had needed a bit more sort of ...control, she was perfect, yet she was still into all the active birth things.

[Julie-midwife and mother of two children]

Julie makes her choice based on her experience of working as a midwife and her insider knowledge both of midwifery and of the unit where she works, and describes those attributes that she feels are important to her. The process of selecting a midwife enables Julie to choose the midwife who she feels will support her approach to practice and will meet her needs in labour. Her primary concern is maintaining control during labour and being empowered in that process to achieve a natural birth. For Julie her emphasis on maintaining normality within the hospital environment is important as she recognises that the hospital environment is influenced by the technocratic approach to labour and birth. Here she makes the distinction between midwives who work in highly technological environments where knowledge of treatment regimes and infusion pumps are important compared with the skills of support required for a more holistic birth in an environment like home.

Providing support for women in labour is key to the avoidance of intervention and the reliance on medication or epidural anaesthesia (Hodnett et al., 2007); however the organisation and culture of the hospital environment may not be conducive to this (Kirkham 1999). Julie's experience as a midwife has to some extent enabled her to differentiate between midwives in this way and to understand their individual ways of working. Although the issue of trust may encompass the issue of competence and safety, it also includes a shared philosophy around birth.

Although choosing a caregiver is considered a perk or a benefit of the privileged, some midwives embraced this opportunity to control the decisions made. To develop this point further, it is useful to consider Anita's experience. As an experienced midwife in her early fifties, Anita talks about assuming control within her birthing experience due to her experience and status as a midwife:

...I chose people to ensure that that [control] would be the case because I was in the position to do so.

[Anita-midwife and mother of one child]

To enable her to achieve this, she chose the midwives who shared her philosophy of midwifery:

I wanted somebody whose practice I respected, my friend colleague qualified much longer than me but she'd practiced the way I did. I saw her... we had similar attitudes, similar ways of working...so I had confidence that she was going to do what I believed in that she would do it and do it well. And my other colleague is a friend slightly different really she wouldn't have been able to cope to be my midwife but she was there bless her supporting me because different personality different way of working...I did have a lot of confidence and faith in them.

[Anita-midwife and mother of one child]

Anita also differentiates between her colleagues in relation to their skills and experience. Whilst she describes both midwives in a very positive and endearing way, Anita's emphasis here is on 'doing the right thing', in which she compares the practice of the first midwife with her own. She identifies her friend as a support and whilst she has trust in both of them, she suggests that her relationship with her friend may be a barrier to equip her to care for her. This is a significant point here because Anita is making a judgement on the ability of her friend to 'cope' with the emotional aspects of caring for her around birth. She accepts that she has confidence and faith in both midwives in terms of support and care they provide during labour. In this context I argue that Anita displays emotional intelligence defined as 'a type of social intelligence that involves the ability to examine one's own and other's emotions and to use the information to guide thinking and actions' (Byrom and Downe 2008:6-7). Whilst this emotional awareness has also been considered as an attribute of the 'Good Midwife', Anita has the experience to recognise that labour is an emotionally demanding experience both for the mother and the midwife.

The emotional investment in the care of a woman in labour varies from midwife to midwife but becomes more complex when midwives are asked to care for fellow colleagues. Anita recognises this difficulty and to an extent protects her friend from the responsibility and accountability for her care by choosing another midwife. Many

midwives express their dislike of caring for other midwives in labour because of the added responsibility and emotional stress of making sure that all goes well and Anita's account above echoes that. Whilst the practice of choosing a caregiver places an additional emotional strain on the midwife, it is important to consider that midwives possess specialised knowledge and are therefore knowledgeable consumers too, as illustrated in Chapter 5. Unlike Anita's approach to protect her friend, midwives who are the caregivers, also instigate a mechanism of professional protection, since they attempt to do their best for their colleagues to safeguard them from traumatic experiences. Being asked to care for a fellow midwife in labour is something that some midwives embrace whilst others like Julie dislike. She talks of the personal consequences of something going wrong and by choosing not to engage in this process she protects herself from the emotional upheaval that could result:

No, I don't like to do it...So I would rather not do it (nervous laugh)...Yes...I just think I would rather not be involved in case something went wrong I think.

[Julie-midwife and mother of two children]

The obligation to make the experience as good as possible for colleagues, underlines not only the emotional aspects but also professional loyalty to 'look after your own.' Although the level of accountability is the same, the emphasis on the consequence of something 'going wrong' illustrates what seems here to be the added personal responsibility of caring for a professional colleague and the emotions which are part of that process.:

I think if it had gone wrong then I would have felt very guilty, that it was, you know, maybe my fault that something went wrong or something. I don't think I'd like to have anybody I know in labour.

[Vicky-midwife and non-mother]

Guilt in this context is also interpreted as a reflection of the midwife's personal practice and individual competence. Vicky as a newly qualified midwife is aware of this as she is establishing her practice and developing her confidence.

Alice talks about her colleague's experience of caring for her family member in labour, when complications at delivery result in an emergency caesarean section and the transfer of the baby to Special Care Baby Unit:

...she hasn't faced it early enough and everybody's time is different but I do believe the longer she puts it off the harder it will be for her to come back and now she says she doesn't want to come back anyway because she doesn't feel she can but it makes me sad because she is such a good midwife.

[Alice-midwife and mother of four children]

While the baby made a good recovery, Alice talks about the devastating effect that the delivery experience has had on her colleague. Her colleague has been unable to return to work as a midwife since the incident, in spite of receiving support. This illustrates the emotional fragility of being a midwife and raises the issue of how midwives find it difficult to manage emotions (Deery 2009), when the consequence of personal accountability during labour and delivery may result in negative outcomes. The emotional consequence of being involved in the care of a colleague or a relative of a colleague is great. The effect on Alice as a midwife is also evident:

...one of my friends daughters has begged me to do her delivery and I said don't even go there, don't ask me, no, I couldn't possibly do it.

[Alice-midwife and mother of four children]

Walsh S (1999:354) makes the point that caring for friends and relatives is considered a privilege but also 'a tremendous burden.' Being asked to care for a colleague is also confirmation that others value and respect the midwife's professional status and verifies the identity of the midwife as 'good'.

By examining the experiences of midwives and their relationships with their colleagues around the time of birth, I have illustrated how midwives conceptualise the identity of the 'Good Midwife' in relation to issues of competence, autonomy and professional status. This discussion has also highlighted the emotional issues that surround the midwife's decision to choose their caregiver and also the awareness of emotional stress and distress that midwives can experience when caring for colleagues. The next discussion will continue the focus on the conceptualisation of the 'Good Midwife' and concentrate on the association between the identity of the good midwife and mothering. In this section, data from both midwives and mothers will be discussed.

THE VALUE OF MOTHERING

From the accounts of midwives and mothers, the emotional support and nature of care received in labour, at birth and during the postnatal period was important. This is particularly significant for some midwives and mothers in this research, who associate the role of the midwife around birth with that of a mother. The care and support provided by the midwife may be considered as maternal support illustrative of matrescent care considered in Chapter 1. In situations where the mother may be particularly vulnerable, the midwife may provide care which is perceived as maternal in nature. To some extent this supports my discussion in Chapter 4 in relation to the concept of parentification

whereby the midwife draws on her skills of nurturing to support the mother. However, whilst some mothers may welcome this, it may be problematic as the midwife may assume a more powerful role in which the mother may devolve control to the midwife who she trusts.

In the context of this discussion, both Carrie and Angela welcomed this maternal approach from the midwife who was an older midwife and also a mother:

...its such a motherly kind of job.

[Carrie-mother of one child]

What is clear from the accounts of Angela, Carrie, Emily and Gaynor is their sense of vulnerability during labour, which the midwives appear to identify and address by their approach. The midwife identifies the mother's need for support reassurance and comfort. References to their own mothers reflect their need for maternal support; unlike Gaynor whose mother was present during the labour, their mothers were absent. Both their mothers are alive although Carrie reported that her relationship with her mother could be better as she lives a long distance away from her. Both welcome what they perceive to be as warm maternal approach of the midwife, which instils in them a sense of reassurance:

I just felt reassured because she sort of mothered me to a certain degree and as soon as I met her I just thought, 'yes, I hope you are going to stay with me the whole time". I actually remember me saying "are you going to be my Midwife?" (Laughs). She said "yes, I'm going to stay with you for the delivery" and I felt so good about that because she was just like a mum (laughs).

[Angela-mother of two children]

... Elinor [the midwife] was nearer my mother's age and I don't know, she, I just felt she really, it was like being mothered really, I know that sounds like a silly thing to say but I felt I was like a child (laughs) in a nice way but she really looked after me and...

[Carrie-mother of one child]

Emily compared the advice she received from her community midwife to that she would expect from her mother. Her account illustrates the sensible 'tried and tested' approach, which she found reassuring and supportive:

...it was like having you know, your mum, you know, just to give you a bit more reassurance....

[Emily-mother of one child]

Mothering can be defined in relation to 'the socially constructed set of activities and relationships involved in nurturing and caring for people' (Forcey 1994:357). Feeling safe is associated with the care provided by a mother for her child and is also prominent in Gaynor's account. Having experienced the care of six different midwives previously,

Gaynor reflects on the reassuring care of an older midwife who uses physical touch to reassure, calm and comfort her through her labour. The seniority of the midwife and the fact that she needs to go out of the room at times adds to Gaynor's sense of feeling safe as other midwives are asking for her opinion. Although Gaynor appreciates the stability and continuity offered to her by this midwife, the presence of Gaynor's mother in the labour room, means that Gaynor does not require the midwife to be present in the room all the time:

...so I think she was more experienced and kind of knew what I was going through so she was helping me...and like she held my hand and was stroking my hair and that helped a lot...Again I think because she was like a bit of a more experienced midwife, although she didn't leave me for such long periods of time, she did have to keep going out and seeing other people on a couple of occasions, someone came in and said "Oh, we need you to come to this room" but I didn't mind because in a way that made me feel better that she was being asked to help out, that made me feel 'Oh, she is good, people ask her for advice and stuff.'

[Gaynor-mother of one child]

In all these accounts being motherly was associated with being older in age and was not an attribute of the younger midwife in this research. The age of the midwife seems to be a significant factor for some in relation to the emotional and nurturing quality of care in labour. My data resonates with Robinson (2004:515) who recounts her memories of the midwife that cared for her; 'She had dark hair, and a warm, kindly face, and I was glad she was older, and somehow more motherly than the crisp, competent younger women who bustled around.' The younger midwives whilst they may have been mothers themselves, were considered to be less motherly but equally capable as midwives. In contrast to Angela's earlier account, she found the experience of being cared for by a younger midwife during her first labour very clinical and detached. What is clear from Angela's account is the approach of the midwife, which illustrates my earlier point in relation to the significance of the midwife's ability to develop a rapport and the use of personal skills in the care of mothers. The emphasis here on the 'textbook approach' resonates with Tracey's account of professional learning in Chapter 4, in which she describes the importance of learning about midwifery from the textbook, as she had no personal experience of pregnancy or birth to draw on:

I just felt as though everything was by the book if that makes sense, it was very clinical, very I've read this in a text book, this is what we do next. It was very, everything was explained to me as though I would expect it to be explained from a text book. I thought with the second one, all those years of experience, it just felt very natural as though it just came naturally, that's the only way I can describe it and I think when you are young you don't have that experience of life to be able to perhaps ask or respond to questions in the same way as if you are a bit older. I know perhaps you know, when I was in my early 20's and I would be very different in my job to how I was in my 30's because you get a bit of

experience of life and you are able to relate to people a lot better and that's just the experience of life and that's with any job. But I think when you are feeling quite vulnerable and you're in that kind of situation, especially with your first baby, I think that no matter how old you are you want to be mothered and I think a young person without children hasn't got that natural way about them because that can only develop through experience.

[Angela-mother of two children]

The context of Angela's account is influenced by the midwife's life experience. She places a great deal of emphasis on what she sees as the natural instinctive approach of the second midwife and associates this attribute not only with her experiences as a mature midwife but also as a mother.

Midwives like Alice also place a great deal of emphasis on the experience of motherhood for the midwifery identity and the ability to care for mothers. She also suggests that young students and midwives need to develop their approach to care:

...the students who haven't got children, who are younger, they just don't seem to have the same, their clinical skills are good but they are not emotionally as caring I would say, that might be the wrong thing to say but they really don't have the same capacity, probably because they haven't had the life experience either, you have to take that into consideration....

[Alice-midwife and mother of four children]

The intuitive nature of midwifery work is clearly important to Alice and although her use of the word 'breed' characterises midwives with children as a homogenous group of women with a single identity who have similar qualities and characteristics, it raises specific questions in relation to the identity of midwives:

I am quite tactile so I am quite, but midwives are I think anyway, we all seem to have this, we are like a breed of something and it is even better when they have had a child because they belong to our breed even more then...I don't know, it is an intuitive thing, just caring about people, if one of our colleagues sees me struggling, they will think to help, they will use their sense and understand or just feel it, it is just a feeling you get for people and situations...mumsy midwives or maternal...it is hard to describe but it is definitely an in-built thing that midwives either learn to have or you gain as you become a midwife, or perhaps you are born with it and it just comes out when you become one, it is a real strange thing but people often talk about it and I know where they are coming from when they say we are one of a kind.

[Alice-midwife and mother of four children]

Her use of the term 'mumsy midwives' highlights four specific issues; firstly, it raises the issue of whether all midwives who are mothers practise midwifery that reflects a maternal approach to care. What is clear from the data is that certain mothers value the level of maternal support which some midwives offer, as midwives known as 'Others' do not have the capacity to offer. It is important to add that not all mothers in this study stated that they required or received care that was considered as motherly so therefore

this may be specific to certain mothers and midwives in this study. Secondly, it questions whether midwives who are non-mothers can develop mothering qualities and skills within their care without becoming mothers. Indeed it is true to say that not all the midwives and mothers interviewed place the same degree of importance on this issue. This also raises the point that midwives who are non-mothers still participate in negotiating maternal identities in terms of controlling fertility meeting cultural and social expectations. In this study Vicky, Tracey and Rebecca, described their skills, which were equally appreciated by mothers in their care. Vicky adds to this:

I don't feel the need that I have to have children to be a good midwife. I know that I can be a good midwife without having them.

[Vicky-midwife and non-mother]

Her emphasis is on gaining experience of midwifery and gaining confidence in her practice. She accepts that she is a caring person and to an extent supports the point that the ability to care and support mothers may be more of an innate quality fashioned by experience and professional education. Both Angela and Mary however use the word natural and instinctive in relation to the midwife's approach to care, which supports to some extent Alice's point about the in-built aspect of being a midwife. This discussion however reinforces the idea that motherhood is a wholly natural status for women and may therefore be an attribute of the 'Good Midwife'. Rich (1976) argues that the relationship between mothering and women's natural identity pays no attention to the aspects of nurturance and patience, since these values are considered intrinsic to the feminine role. Mothering therefore is considered a selfless act, which 'comes naturally to women' and as a result motherhood is generally devalued within society. This 'institution of motherhood' (Rich 1976) in which the ideology of the 'perfect' and 'good' mother exists, constructs a standard by which all others are measured. In the context of this thesis, I argue that the conceptualisation of the identity of the 'Good Midwife' in relation to mothering and the maternal role is potentially problematic, since it creates another example of 'Othering practice' in which midwives who are non mothers and young midwives may be considered as 'Others.' 'Othering' in this context may be associated with prejudice, stereotyping and marginalisation. Thirdly, the previous points also raises the issue of gender and the midwife and in this context the presence of the male midwife could be considered as 'Other'. Many mothers considered midwifery to be a female domain. Angela, Dawn, Emily and Laura's accounts highlight their beliefs that midwifery is a female profession. There is an association between midwifery and motherhood, which

Angela and Emily believe is important, as motherhood is biologically a female experience. Whilst some midwives do not have children, there is an assumption here that the desire to have children and to be a mother is an underlying reason for becoming a midwife:

I guess if I'd had a male Midwife I would have been shocked because I think you just assume it's going to be a woman...I think you expect women to have that natural instinct in them that you just assume that we're all going to have children one day and I guess if they are in the job that they are in, they probably like babies so they are probably going to have a baby, if they haven't already....

[Angela-mother of two children]

Personally I would find it easier to talk to a lady. I think more that you have a certain, even if you haven't got your own children, I think you probably have a better instinct, perhaps I am being a little bit unfair and perhaps a bit sexist but I think you probably have a little bit more instinctive things to do know what to do with children than men but on the whole I think I would find it easier to talk to a woman regardless or not whether she had had her own children.

[Emily-mother of one child]

Gaynor is very specific about the importance she places on the care received from a female midwife and states that she had made it clear in her birth plan. As a young mother she is very aware of the intimate aspects of birth and for this reason she feels that she would be more comfortable with a female midwife. Being comfortable and at ease with the exposure of the body during examinations and at the time of birth is very important for mothers. The issue of the intimacy of birth was considered to be the reason why they consider a man would not be suitable. Dawn makes the comparison here between the smear test and care in labour to highlight the nature of the physical aspects of care:

I think, you know, women in general I think would feel more comfortable with a woman just because, you know. I know loads of people like wouldn't go for a smear test with a man.

[Dawn-mother to one child]

Tania and Laura also suggest that men are seldom suited to this role because of the intimacy involved but also because reproduction and birth are female experiences:

I don't think, I don't think it's a man's role really.

[Tania-mother of two children]

Because I suppose it is having a baby is something women do. Men don't do it.

[Laura-mother of two children]

Carrie expands on this point and describes the experience of having her midwife pour water over her abdomen when she was in the bath during labour as a very tender intimate moment, which she could not envisage a male midwife being involved in:

I was having a bath and having this water gently you know, poured over my tummy, it was actually quite, you know, it was quite an intimate thing.

[Carrie-mother of one child]

Mary raises the issue of competence and ability to fulfil the requirements of the job, which she suggests that a male midwife would be able to do. However, whilst this may be the case she adds that she would prefer a female midwife because she would be able to relate to her. Developing relationships with caregivers is an important issue during pregnancy and childbirth and Mary like so many mothers value the commonalities, which link midwife and mother:

...I mean if that person can do the job and is competent and qualified to do the job well then it doesn't matter who they are, you know, at all, like I say a student, male, female, black, white, whatever, really if they can do the job then they should be there so yes, I don't have a problem with that at all...myself if I had the choice I would choose a woman, only because I think they could probably relate more...

[Mary-mother of one child]

However expectations of the midwifery role is clearly noted in Belinda's account where she would still expect good communication and partnership during the process:

I would want him to be the same as a female Midwife you know, just to let me know what's going on, I wouldn't have any problems in terms of his sex, it's only like a male Doctor or GP or Consultant that's still you know, I'd just expect the courtesy which from anyone, male or female, yes.

[Belinda-mother of two children]

Comparisons with other male healthcare professionals were however made to justify the presence of the male midwife and to some extent challenge any issue in relation to intimacy. Whilst the majority of mothers in this research experienced caesarean sections and instrumental deliveries, their accounts reflect their experiences of a very medicalised and technocratic approach to birth, in which the majority of obstetricians are male. Both Eloise and Fiona consider the sex of the obstetrician in the same context as that of a midwife and no differentiation is made between them:

Well the doctors were all male. So what's the difference?

[Eloise-mother of two children]

...I don't think that would bother me at all. I mean you know, because obviously the medical staff they were male.

[Fiona-mother of twins]

The ability to have children was considered by Megan to be a focus of the development of the relationship with the midwife. However if the midwife was male, she considered that his sex would not be a barrier to the development of a relationship but she would consider that relationship to be different:

I wouldn't have a problem with that [male midwife] at all... without having gone through that experience they are not going to really understand but I don't see a problem with developing a relationship of some description that would work.

[Megan-mother of two children]

Belinda, Eloise, Fiona, and Jessica, draw comparisons between the presence of the male midwife and the dominance of men in medicine and therefore do not consider pregnancy and birth to be different or female focused:

I don't think it would bother me if the midwife was a male and I think like often if you go to a male doctor particularly if it is for a woman's thing problem with periods or whatever, they tend to be a lot more sympathetic. Women doctors say "Oh for Gods sake, just get on with it" you know.

[Jessica-mother of two children]

This discussion suggests that the sex of the midwife is not a concern for all mothers. Those who emphasise the value of the maternal approach to care unsurprisingly favoured the presence of a female midwife.

Thirdly, the issue of the visual representation and image of midwives merits consideration. Some mothers like Emily and Mary used the term mumsy to describe midwives' physical form, which creates parallels with earlier work (Hallam 2000) on the image of the District Nurses and the traditional image of Matron in popular culture such as in the 'Carry on' films. Certainly some mothers use the word 'matronly' to describe their image of a midwife:

...I expected somebody, although we all have a preconceived idea of somebody probably quite older, more kind of mumsy and quite sensible, very reassuring but then, and I felt my midwife was nearer my age, wasn't really the stereotypical person that you expect...Probably television and books and you just imagine your kind of community midwife you know, portrayed as some kind of portly 55 year old lady who has been doing it for years who is quite matter of fact and brisk but just who, you know, just who you feel very comfortable with and offers great advice and perhaps not so much of the kind of faddy trendy stuff that you read in your books now.

[Emily-mother of one child]

...when I say mumsy, motherly, I suppose I mean caring, not that I am saying people that are caring, you know, all have to be mothers, I don't know, just how I would perceive, you know, I can't explain it. Just somebody who is very, very caring I suppose, very sympathetic, you know, listening, very, very caring.

[Mary-mother of one child]

The image of the midwife in this context is contrasted with the image and therefore identity of the hospital midwife who may wear a generic uniform or theatre scrubs. The expectations of mothers therefore may be influenced not only by the image of the midwife but also what that image represents in relation to the approach to care. The imagery created in these accounts highlight the image of the handywoman as described in Chapter 1. The problem here arises when the image and expectation of the midwife does not conform to the appearance of the midwife in reality.

This part of the chapter has considered the value of mothering and the maternal role as experienced by the mothers and midwives within this research. Whilst not all midwives or mothers described the importance of the mothering approach to care, some identified it as a representation of the nurturing approach to the care of mothers. However the emphasis on mothering raises issues of 'Othering' in relation to non-mothers, young midwives and the male midwife, although it must be remembered that this is considered in a theoretical context in this thesis. The last part of this chapter continues the discussion of 'Othering' in relation to midwives' experiences and mothers' experiences of midwifery care.

MIDWIVES' CONCEPTUALISATION OF 'OTHERS'

Midwives draw on a number of experiences to describe midwives who display a range of behaviours that do not meet their expectation of the midwife or concur with the identity of the 'Good Midwife'. Some midwives also identified colleagues who lacked enthusiasm and motivation and displayed poor attitude in practice. Although midwives draw on their experiences of birth ranging from between 3-28 years, midwives were represented in similar ways, which was supported by mothers' accounts of their recent experiences of the maternity services which will be discussed later in this chapter. Rejecting midwives who lacked motivation was a major factor for midwives in their decision to choose a suitable caregiver. However, in this discussion it is important to consider that mothers do not have the same degree of autonomy and although several voiced the possibility of asking for another midwife due to the poor attitude of the midwives, none pursued this option: and this will be considered later in this chapter.

Susan described a midwife who has lost her motivation and enthusiasm and displays a negative view of work. For midwives who have lost the enthusiasm for midwifery, working becomes a job that is done and pays the mortgage. Susan identifies these midwives:

...the ones that roll in and say 'Oh God back again' and I think 'Oh dear' and they're the ones I certainly wouldn't want to look after me or my daughters,

[Susan-midwife and mother of two children]

The lack of motivation is reflected in the way in which midwives communicate with colleagues and mothers. Midwives within the study group, identified that some of their colleagues were very abrupt and rude to women and colleagues. Rebecca talks about the midwives she would not like to look after her:

There is a couple of midwives out there, they are just very abrupt and they have just not got very nice people skills and I have heard the way they treat the women and the way they talk to the women and the way they talk to members of staff and I just think 'oh dear, no, I wouldn't like you to look after me' because they are just rude really.

[Rebecca-midwife and non-mother]

The presence of 'people skills' is also echoed in the literature as positive attributes of the midwives (Fraser 1999) and underpins the midwives role in the provision of care that centres on the needs of women. This echoes my discussion of the importance of the relationship between the midwife and the mother in Chapter 1. Being rude and abrupt lessens the possibility of the development of rapport and the experience of birth is greatly affected as a result.

In Jackie and Alice's accounts, attitudes towards young mothers are particularly negative and reflect the level of prejudice. Jackie describes her experiences of working with an 'old school' midwife. Whilst a number of midwives within this study have described older midwives in different ways, the use of the word 'old school' has a negative connotation in this case. Her attitude towards young mothers is clearly described and reflects the culture at a time when prejudice and discrimination towards young mothers were visibly entwined in practice:

...she was also an old midwife who had a real thing about single women because in those days, everybody was Mrs, everybody was called Mrs, and she would take great delight in crossing out Mrs and writing Miss and making terrible assumptions and things and also had the attitude that if they were single and came in pain then you know, 'serves you right', she was horrible, she was horrible...I heard she got struck off actually. That is good, she needed to be struck off, she was not a good midwife and had a terrible attitude and lazy to boot...

[Jackie-midwife and mother of three]

Her comment about being struck off the professional register supports her own views of what good practice should be and how good midwives should behave. As a young midwife herself at the time, she takes personal offence to the negative and discriminatory attitude towards younger women. Alice too describes her experiences of giving birth when she was a young married woman. Her account also highlights cultural and social prejudice towards young mothers:

...my first child, it was a very rapid labour, the midwife was very unkind, I was only just coming up to 18 years old and her attitude was well if you were old enough to open your legs to get yourself pregnant you are old enough to get it out now without so much fuss. I felt that I was quite unprepared for childbirth because being young, even though I was married, I hadn't been to parent classes and I hadn't prepared very well, I was only going on what other people had said and not many of my friends had actually got children so I found it very painful although quick experience, my husband was with me but I wasn't asking any questions and it was very different to how we treat young girls today.

...with hindsight I thought if ever I did this job I would never be like the midwife was with the first one particularly, she was horrible, she was very aggressive, she was old as well and obviously had a thing about teenage pregnancies and was most unsupportive and you know, shouted at me and told me to stop making a noise and stop being silly and if I was old enough to get pregnant, I was old enough to deliver and all this sort of thing, so she was the worst sort of midwife and I would never want to role model myself on anybody like her.

[Alice-midwife and mother of four children]

The absence of kindness in Alice's account is clear. She is clearly affected by the behaviour of the midwife who appeared to be very dismissive of her. Within this account Alice describes the attributes she identifies as being negative and unacceptable. The need for support is particularly prominent here, as she describes herself as being vulnerable, unprepared and scared:

...their births were really nice but particularly the care I had at the new hospital was just absolutely amazing, I had a really kind midwife...they were really kind....

[Alice-midwife and mother of four children]

Kindness can be a reflection of the concern that an individual has for another. Susan describes an incident that occurs at the end of the shift when the senior midwife is handing over to the night staff. She answers the buzzer on labour ward to find a mother who is about to birth her baby:

...I answered the buzzer at ten to ten the other night and we were due to go home but, the buzzer was going and I knew she was a multip and you know and she was in labour so I answered the bell and she said 'I really need to push' and I said 'Oh hang on I'll get the midwife that's looking after you' and I knew who it was and with that she walked in the door and 'I knew this would happen' as she was putting her pinny on, 'I was just going to make a phone call' and I thought how rude is that, how rude is that...miserable.

[Susan-midwife and mother of two children]

Susan has clearly identified this midwife from her experience of working on labour ward and her behaviour does not appear to be unexpected. The midwife's reaction is negative which may reflect the thought of having to stay beyond her shift to prepare for a delivery. Although this may be a personal inconvenience, expressing this in front of the mother is considered unacceptable and rude. Susan is aware of the potential effect of this reaction on the mother and her partner. This raises the point considered in Chapter 5 in which demands of work and home place a personal burden on midwives where family responsibilities do not allow any flexibility especially in relation to staying beyond the end of the shift. Although this may challenge the midwife's motivation and ability to provide woman-centred care, maintaining a balance between work and home can be difficult.

Trish describes her experience of being cared for by a midwife in the unit she used to work in. Her care was considered poor in so much that the midwife did not seem to be

able to communicate well with her to a point where Trish felt that she really did not assess her needs and listen to her:

Yes I think a lot of it is personality particularly with midwives that you know, because you know the people you get on with and those that you don't so I think people that you know ...It's whether you feel that the midwife is sympathetic to you or whether she's going to be completely domineering [...] or what have you...and whether she's prepared to listen to what you want because it's not only being prepared to listen to what you want but it's actually almost not be a mind reader but try and read between the lines.

[Trish-midwife and mother of three children]

In Trish's account she is particularly focused on the fact that she was not given a choice of midwives to look after her in labour. In fact she describes a situation where she is left very much on her own with her husband. She feels very unsupported by this midwife and when the midwife announces that she is going home when Trish is approaching second stage of labour it is the final insult:

So she then did another VE and obviously I was fully dilated and he was just sitting there and then, so, then the night staff came on at quarter past and she said to me, she said, 'I am actually going to hand over to the night staff now because I am going off duty. ' So I felt very upset about that as well because I thought surely, you know, I know its nice to get off home on time, but you don't want somebody else walking in just as you are going to, even though I didn't really know this midwife anyway, I was just so delighted because my friend [...] walked in and I can remember thinking, I have never been as pleased to see anybody in all my life, see my friend [...]

[Trish-midwife and mother of three children]

Approachability is important here and the friendship between Trish and her colleague enables her to relax. The contrast between these two descriptions highlights the fact that midwives have very supportive roles to play during the labour process. Whilst a number of mothers are cared for by midwives whom they have never met, building that instant rapport is important to enable the mother to feel at ease and this has a positive psychological effect on the mother's labour.

MOTHERS' CONCEPTUALISATION OF 'OTHERS'

Whilst midwives described as good, lovely and great, appeared to be embracing their work as 'more than a job', 'Others' were described by mothers as 'just doing their job.' The distinction made here revolves around the emotional engagement with mothers and affect of this approach on their experience of pregnancy and birth. The following discussion is focused on the mothers' accounts and illustrates situations in which mothers' encountered midwives that offered little emotional support. It is important to highlight that all mothers enjoyed the relationship with their community midwives, usually referred to as 'my midwife,' although this midwife rarely cared for the mother in

labour and at birth. The value and contribution of the community midwife to the care and experience of the mother will be discussed in more detail in the next chapter. The accounts discussed here focus on the interactions of mothers with midwives who cared for them in hospital during labour and at birth.

Dawn's account describes how the midwife formalises their first meeting by focusing on the consent for the vaginal examination:

She was quite a cold woman; she was quite young, well I would say, thirtish. But she just seemed very cold and clinical. It might have been because she had three other patients to deal with, but I don't really care about the other three. When I going through one of the biggest things that is ever going to happen to me and yes, I just found her very kind of cold and, you know, she has to do her job and stuff, and like, well one of the points was, I suppose she has to do it but it just struck me as being a bit strange, when like, she asked me to do an internal exam and she was like, "I am going to have to examine you to see how far gone you are and see if your waters are broken", like yes, OK. And like she stood there with all her equipment saying, "so do you give me consent to do an internal", and I am like, "do what the hell you want to do, just get it over", and you know, do you want me to sign a form, it was just do it, do it, you know, I am kind of in a bit of, I want to get it over and done with and be dealt with and I don't need to sort of start the process and I don't want you to stand there sort of asking these data protection questions...but she was matter of fact and get the job done.

[Dawn-mother of one child]

Having arrived at hospital in labour her first impressions of the midwife are very poor. Although Dawn acknowledges the fact that the midwife is caring for three other mothers because the midwife informs her of that fact, she expects the midwife to focus on her and her situation. On the contrary, by stating that she is busy and caring for other mothers, the midwife may be using this information as a strategy to justify her brisk approach within a busy environment. Her use of the word cold reflects the midwife's emphasis on the clinical aspects of the assessment. The midwife presumably in her attempt to manage the caseload of mothers in her care, approaches Dawn in a very task orientated way, which may be perceived as objective and emotionally detached. Her matter of fact approach illustrates her emphasis on the elements involved in the assessment of labour. Her approach irritates Dawn who is in labour and wants to have pain relief and the reassurance that all is well.

Fiona, a mother of twins also describes the midwife as having an excessively professional approach, to the point of being over efficient and distant:

The midwife that I didn't get on with and didn't like was very professional seeming, you know, sort of very efficient and so on but to the extent of not being necessarily giving you

the time that you wanted, and although the other midwife that I did like, she was very efficient but she was also, she was very, much more relaxed....

[Fiona-mother of twins]

As a mother of premature twins, Fiona feels that the midwife is unable to provide her with the support she needs to care for the twins. In both these accounts the emphasis on the lack of time is suggested to prevent the midwife from engaging with the mothers in a way in which they can provide the support and reassurance that they require.

Belinda expresses her disappointment and anger following her care from a midwife during her first labour:

Belinda: I mean just going back to the one, my first pregnancy and kind of, it was almost as if you know, she was doing that job and she didn't want to be doing it but that was everybody's fault but her own...it's not my fault that perhaps she wasn't enjoying her job and it's kind of if she wasn't enjoying it then she should really leave rather than take it out on people.

Sarah:...how does that kind of midwife come across then?

Belinda: In their attitude I mean like, it's very hard to explain really because it's kind of that interaction at the time but you know, someone that huffs and puffs and everything is too much trouble and you know, they wonder off and they wonder in and don't really say anything and they see that you are still in the same position that you were in, you haven't changed, you haven't got any more dilated than you were last time and that's a bit of a hassle because you know, you are not ready to push your baby out yet and that's how it was, it was ...I talked about this Midwife with friends and people afterwards and my friend used to work, she was training to be a nurse and she said that she had done the same, that she had met several Midwives she knew who were just really miserable in their work and all that kind of thing, but it's a shame if you end up *with one of them*, but you can't pick you can't. When you are in that situation it's not as if you can say "you know what, I don't feel very supported by you, can I have a different Midwife", but I think if I'd had had someone like that and if I'd gone through a natural labour this time, I might have said something to her you know, in terms of, you know, "you're not particularly very helpful" I really do think that a lot of people probably wouldn't and I think that's a real shame because it should be such a wonderful experience and if you get someone like it makes a difference between having a really, really wonderful experience and delivery to having one where you feel a bit pressured or you know, that you are being an inconvenience.

[Belinda-mother of two children]

Belinda feels she is being made to feel responsible for the midwife's apparent unhappiness and dissatisfaction with her work. Her poor behaviour and apparent lack of engagement has a negative effect on Belinda's enjoyment of this experience. Her use of the phrase '*with one of them*' is significant here as it characterises the 'Other' as a midwife who has lost interest in supporting mothers and is disengaged from the process of making mothers the focus of care. This phrase is also interesting as it implies some kind of categorisation of midwife. In relation to the midwives approach to pain relief, McCrea, Wright and Murphy-Black (1998) report three different kinds; these were the

'cold professional', 'a warm professional' and the 'disorganised carer'. The cold professional kept her distance and was emotional detached, whilst the warm professional showed empathy and compassion and was a friend. Although the disorganised carer was neither professional nor empathetic in terms of the care she provided, she was described as nice as she appeared pleasant and friendly.

Although this labour experience has empowered Belinda to question this behaviour and attitude, it is even more significant to her since her second child was born by an elective caesarean and therefore she did not experience labour again. Its effect can be felt in her need to discuss her experience with her friends. This account highlights the poor relationship between the midwife and Belinda and her vulnerability and the need for support, which was not met. Not only does Belinda feel an inconvenience being in labour with a baby in a breech position, with an epidural, she clearly identifies the fact that if she were in normal labour she would expect more support from the midwife, in terms of talking her through contractions. Whilst caring for a mother in labour with an epidural could be considered as a technically managed labour in which the mother may not be feeling the pain of contractions, Belinda is still in labour and requires psychological, emotional and physical support. In contrast to the experiences of midwives who are given the opportunity to choose the midwife as their caregiver, Belinda's account illustrates the vulnerability and helplessness of mothers who need support but feel unable to complain about the midwife allocated to care for them.

CONCLUSION

In this chapter I have presented a discussion on the identity of the 'Good Midwife' and the identities of 'Others' as described in the accounts of midwives and mothers. I have illustrated that midwives participate in a process of 'saming' and 'othering' as a way to determine their own identities as midwives but also as a way to describe the difference between them and 'Others.' Whether midwives use this approach in their relationships with mothers was not determined in this research, although work on stereotyping (Kirkham et al., 2002) and discrimination (Cross-Sudworth 2007) may be evidence of where it could occur. However, it is clear that mothers use 'Othering' to determine the difference between midwives who were considered as 'good midwives' and those who were not.

It can be concluded that the definition of a 'Good Midwife' varies between the two study groups in relation to the importance of upholding professional standards of competence and the presence of personal attributes, which concur with the findings of previous work (Nicholls and Webb 2006). Midwives chose caregivers who shared their philosophies of care and those who they felt would ensure that their requests would be adhered to. Whilst none of the midwives or mothers described midwives as 'bad', their negative descriptions of midwives' reflect the poor attitude of midwives rather than their performance of tasks. Therefore I suggest that both midwives and mothers expect their caregivers to display a caring attitude as a specific aspect of their identity. This is particularly significant as it is a reflection of the extent to which midwives are emotionally connected to mothers and also their enthusiasm for midwifery work. Whilst this emotional connection can be displayed in different ways, a general attitude of concern articulated through good communication skills seems to be a basic requirement, which appears to be absent in some of the accounts considered in this chapter. Furthermore, I suggest that some mothers value a more defined emotional connection, which I describe as emotional engagement. This encompassed a more intense relationship, which was illustrated in this research by the use of female mothering qualities of care and support around birth. Data from some of the interviews with midwives and mothers suggested the contribution of mothering experience to the identity of the 'Good Midwife' was important, although midwives who were non-mothers consider that they did not need to be mothers to possess mothering skills. The data in this chapter has also illustrated that midwives consider midwifery as emotion work (Hunter 2004a; 2004b; 2005). The implication of this emotional investment for midwives, especially for those who choose their caregivers and for those selected by colleagues to be caregivers during birth, was also evident. In this context I use emotion work to encompass both the public and private expression and management of emotion in relation to midwifery work.

Whilst younger midwives and midwives without children were considered to be different in terms of their ability to be emotionally connected to mothers, in the introduction I questioned whether the identity of the male midwife might be considered as 'Other' in the context of gender. Whilst for some mothers the issue of gender was not a problem, others questioned the presence of a male midwife in relation to the intimate aspects of birth and some doubted men's suitability for the role because of their gender and lack of reproductive experience. The issue of gender therefore appears to be an issue for some

mothers more than others, although it is fair to point out that none of the mothers interviewed had received care from a male midwife at the time of the research. The identity of the midwife considered as 'Other' was therefore considered in the main in relation to poor attitude and behaviour. Midwives who were described as 'just doing their job' were considered to lack the people skills that 'good midwives' seem to possess. Whilst there was no suggestion of incompetence, these midwives appear to be less emotionally connected with mothers and from the interviews at the time of this study, appear to be confined to the hospital environment. However the experience of birth was marred for many midwives and mothers by their perception of the attitude of the midwife.

Whilst this current chapter has shown that mothers have expectations of the midwife in relation to the emotional aspect of the midwife's identity and midwifery care, it raises questions about what is meant by 'care'. This issue is explored in the next chapter which focuses on the identity of the midwife as carer and draws on the accounts of mothers and their encounters with midwives.

CHAPTER 7

THE MIDWIFE AS CARER: MAINTAINING A WOMAN-CENTRED IDENTITY

INTRODUCTION

In the previous chapters, I have established how care is considered a crucial aspect of the identity of the midwife which is enmeshed with the gendered identities of motherhood and how the identity of the midwife is constructed as 'Other' when caring is perceived to be absent. In this last data chapter, I extend the previous discussions to focus on the nature of the relationship between the midwife and mother, to illustrate how identities are constituted in these interactions between midwives and mothers and the centrality of gender in these processes.

This chapter has two key aims. Firstly I illustrate the extent to which midwives as women can claim the identity of carer in terms of the ways in which they facilitate care to meet the needs of mothers. In Chapter 1, I considered how the relationship between gender and midwifery in relation to the essentialist claim that midwifery care embodies the female qualities of nurturing and support. Secondly, since midwifery is principally organised around the philosophy of woman-centred care (Leap 2009), I consider how the care described by the study group of mothers reflects the principles of this philosophy. The basic principles focus on partnership working, where the woman maintains control over the decisions made jointly between her and the midwife based on informed choice and continuity of care. To underpin this discussion I consider the dynamics of the relationship between the midwife and the mother, from the perspective of the study group of mothers as recent consumers within the maternity services.

In order to explore this further, data within this chapter have been analysed according to the theory of care developed by Swanson (1991), which I introduced in Chapter 1. Care is defined as; 'a nurturing way of relating to a valued other towards whom one feels a personal sense of commitment and responsibility' (Swanson 1991:163). This theory is characterised by five key processes; 'knowing', 'being with', 'doing for' 'enabling' and 'maintaining belief,' reflects the philosophy of woman-centred care and the relationship that exists between midwife and mother. This framework permits a more critical examination of how care is defined in the context of woman-centred care, how the

mothers interviewed in this research experienced midwifery care and their perceptions of care they received. For the purpose of achieving the aims of this chapter, the discussion will focus on the analysis of experiences during the antenatal period, labour and during the postnatal period and presented along this continuum.

More specifically, this chapter is presented in four parts. In the first part I consider the nature of the relationship between the midwife and the mother by drawing on the data in relation to the mothers' antenatal experiences. The importance of 'knowing' is explored here in terms of the effect of the midwife's knowledge and understanding of the mother. The second part explores the process of 'being with' and 'doing for' in relation to the issue of support in labour for both the mother and the male birth partner. In the third part I consider the value of support for mothers who breastfeed and mothers recovery following caesarean section and focus on the process of 'enabling' and 'maintaining belief' as key moments in maternal identification and experience. The concluding part will consider the mothers' perceptions of midwives as an oppressed group of carers.

ESTABLISHING RELATIONSHIPS

The data suggests that the relationship developed during the antenatal period serves as a foundation for the whole childbearing experience even though community midwives did not attend the mothers in labour. For mothers within this research, the nature of the relationship with the midwife is dependent on the extent to which mothers feel the focus of care. This is a significant aspect for the majority of mothers because they value the midwife's efforts to know and understand them as individuals, upon which care is organised to meet their needs. For Jessica, a mother of two children, her immediate assessment of the midwife illustrates her expectations of the midwife as a carer during her second pregnancy, which sets the scene for their relationship:

...when I meet somebody it's dreadful I make a judgement very quickly about what I think of them really and whether I can trust them and the community midwife this time that I met at the Surgery, as soon as I walked in she said "hello, Jessica, come in, sit down, it is so lovely to meet you, oh look at you", straight away I thought 'I like you' because she made me feel at ease and comfortable and also I had my own experiences of having been pregnant before and having had the birth and bringing up a child and I didn't have the same needs, I wanted the reassurance that my baby was OK, I wanted advice as to whether she thought I should have a caesarean or not and she gave me the best advice in the world and was really, really thoughtful and that was all I needed from her at the time, I didn't need that constant panic of oh no, because I knew and I understood my own body a little bit better.

[Jessica-mother of two children]

In this context Jessica values the nature of the support provided by the midwife, which is based on her needs in relation to caesarean section. Her needs are different during this pregnancy; whilst she still requires the reassurance that her pregnancy is progressing well, her relationship with the midwife is different because she already has a child.

For Angela, a mother of two children, the effect of being the focus of the midwife's attention is a positive and enjoyable experience:

I think somebody that makes you feel as though you've got all of the time in the world to talk to about any concerns that you've got and make you feel special and I think being pregnant is special anyway and in a way I miss being pregnant because you do get quite spoiled with attention and people fuss over you and I think it's nice, ...I like to know everything that was going on so I would ask a lot of questions and I think as far as a Midwife for me, I needed to know that that person understood me from the start and it wasn't text book, it wasn't sitting down reading notes ticking sheets, it was actually sitting down and finding out about me....

[Angela-mother of two children]

Being pregnant is a unique time for Angela, which evokes a feeling of being 'special' and different. Being the focus means being listened to and, as a result, concerns or worries are understood by the midwife and addressed appropriately. Communication is an important aspect of this relationship in which Angela emphasises the importance of conversation as a means of getting to know each other, rather than relying on notes in a systematic and clinical way. This relationship therefore is more than a professional one; it is a personal one in which Angela takes an active part in decisions made about her care. In this context, the relationship is a partnership in which the balance of power lies equally with the mother and midwife. Whilst this relationship has been described as a 'friendship with a purpose' (Page 2003:35), mothers in this research also recognise that it is a transient and time limited experience. Some of the mothers like Jessica, Angela and Carrie consider their relationships with community midwives as 'professional friendships' (Pairman 2000), in which they feel relaxed and comfortable with the midwife and feel that she is concerned about them as individuals:

I really looked forward to my antenatal appointment you know to hear the heartbeat and have a chat with her and answering the hundreds of questions I had...I think it would have been a great shame if I hadn't felt so relaxed with the person looking after me. I would probably have been much more anxious....

[Carrie-mother of one child]

Finding a connection is a real aspect of the relationship which brings both mother and midwife together:

...she is a friendly, bubbly lady and it helps that she lives in the village because I mean we instantly had something in common....

[Carrie-mother of one child]

For Angela, the presence of the same community midwife during her second pregnancy some eighteen months after her first baby is born, is really appreciated and brings with it a sense of trust and reassurance:

I thought it was great that she remembered me, so we did have...a really, really good relationship on both occasions really.

[Angela-mother of two children]

Others accepted that the relationship was a necessary professional one and the personal connection was neither established nor missed:

I didn't really find that sort of connection with her...She wasn't really my cup of tea. Although she was very nice...she did everything, you know, I didn't mind going to her and having my checks at all.

[Tania-mother of two children]

For Tania, a mother of two children, the relationship with her midwife during her second pregnancy was not based on a friendship; the personal aspects were not as important but the midwife remained as carer even though the relationship was more professional and distant.

The relationship for some mothers is more than just knowing who the midwife is, it is the extent to which the midwife can demonstrate that they know and understand the mother (McCourt and Stevens 2009). This is an essential part of the assessment of needs and risks, and ultimately to the progress and outcome of pregnancy. The strength of the relationship that frames this process of knowing may not be necessarily enhanced by an increased number of antenatal visits. However, whilst the majority of the mothers within this research received traditional shared care or midwife only care, antenatal visits were arranged according to the needs of the mother. Belinda's account describes a situation that challenges her understanding of her relationship with the community midwife. Although Belinda did not feel that she has established a relationship with the midwife during her second pregnancy, she is surprised to find how receptive and intuitive the midwife is to her personal situation. She does not intend to share the information about her father's death with the midwife, because she does not feel that she knows her well enough:

I mean one thing that was, I found quite surprising was I lost my dad, my dad died when I was about 25...weeks pregnant which is obviously devastating and I went to see the Midwife and automatically she said to me "what's wrong?" And then although I hadn't

really known or built up much of a relationship she obviously picked up because I didn't mention anything the minute I got there and she said, "you're not yourself, what's wrong?" And I ended up obviously saying "I lost my dad" and I think it was like the week before my dad had died and then I'd had an appointment for the week after and in fact I bawled my eyes out with her and I thought that was quite telling because obviously you know, I felt safe enough to do that with her and from that point she was very sort of you know, she would check in on me in terms of how I was feeling and you know, whether she would have done that had I not shared that experience with her I don't know but the fact that she picked up immediately without me saying anything that I wasn't myself was really, really, really appreciative you know.

[Belinda-mother of two children]

Although this is a different midwife from the one that Belinda knew during her first pregnancy, she creates a safe and supportive environment for Belinda to disclose this information. In this context the number of visits does not influence the midwife's assessment of Belinda. Rather the midwife's attentive assessment of Belinda's situation identifies the need for additional support. Disclosing the information about her father's death changes the nature of the relationship between them. The potential lack of opportunity to share this information may have placed Belinda in a very vulnerable position, which the midwife recognises as a potential source of psychological distress. The provision of additional antenatal visits focus on Belinda's individual needs and on the midwife's ability to assess her psychological state.

The relationship between the midwife and the mother may be influenced by the nature of antenatal care provided based on the needs of the mother and the assessment of risk. The recommended schedule of visits (NICE 2008), differentiate between the provisions of care for mothers considered low-risk and for those mothers who require closer surveillance due to identified risk factors. Angela describes her relationship in terms of the varied length of the appointments and the nature of the discussion with the midwife, which reflects her need for information and advice. Her account describes a relationship whereby she is empowered to ask questions and to discuss her concerns within a safe and trusting environment:

I didn't think the appointments, they never seemed rushed, always had enough time for anything, you know, sometimes it would be a ten minute appointment, sometimes it would be a half an hour appointment if I have got any particular worries, just things that you had concerns about and they just sit and chat and just reassure you about everything....

[Angela-mother of two children]

Reassurance that the pregnancy is progressing well is supported by the provision of information, which as Mander (2001) suggests, is more than relaying facts, it is the sharing of information that enables the mother to feel cared for.

Accessibility is of significance to mothers in this research; both Angela and Emily welcome the ability to seek information and advice from the midwife when they need it. Midwives facilitate access in different ways within these accounts. Although Emily, Tania and Carrie, view their relationships with the midwives in different ways, they nevertheless establish relationships that enable them to seek access to the midwife when information or support was necessary:

I had no hesitation if I needed to, to ring her or pop into the surgery.

[Emily-mother of one child]

...if I felt like there was anything wrong I could ring them anyway and get an appointment... I could go when I needed to.

[Tania-mother of two children]

I never worried about picking up the phone...or I never felt that she was trying to hurry the appointment along or anything like that.

[Carrie-mother of one child]

Emily feels that good forms of access in between antenatal appointments is a way of ensuring that she is able to receive support and information at a time when concerns arise. The flexible approach in these accounts, indicate that whilst midwives offer a different schedule of visits dependent on need and risk, the midwife puts into place forms of access which enable mothers to contact her at other times. In this research this contributes to what McCourt and Stevens (2009:31) describe as going “beyond’ their job.’ This is especially clear when Carrie describes her experiences of contacting the midwife following a fall when walking her dog:

...the fact that, you know, she could easily have said to me, “well I am very sorry. I finish work at 5 o’clock.” but she didn’t. She had strictly speaking finished work and she still came to see me, and I was really touched by that and everything was fine.

[Carrie-mother of one child]

In this context, the midwife’s readiness to visit Carrie after she has officially finished work demonstrates her emotional commitment and whilst Carrie appreciates this, the extent of the midwife’s enthusiasm to women in her care, is evidence of how midwives find it difficult to balance work and home. In Chapter 1 I discussed the additional demands of woman-centred care; the issue of ‘burn out’ amongst team midwives illustrates the possible risks attached to emotion work involved in meeting the needs of women (Sandall 1997).

For some mothers, the changes in the number of visits offered by the midwife is perceived to affect the quality of the relationship. Although a reduced or a flexible

number of antenatal visits appear to have no direct affect on the outcome of pregnancy, studies have shown that mothers feel that they do not get as much psychological support (Clement et al., 1997). Laura, a mother of two children born by Caesarean sections, found that the reduction in the number of antenatal visits during her second pregnancy influenced the relationship between her and the midwife:

This time I don't feel there is much of a relationship because I felt this time I've had far fewer appointments...And I really just felt that you just turn up and that's that, whereas I did feel the last time I did build up more of a relationship with the midwife.

[Laura-mother of two children]

Living a long way from her family, Laura reflects on the closeness of her relationship with her midwife during her first pregnancy three and a half years earlier. In this pregnancy the midwife is considered to be the main source of support:

She was quite nice because I probably did ask her lot of questions first time round. When I, even after, long after having had my daughter, if I was down at the clinic and I'd happen to see her she'd, she'd always recognise me and ask how I was and, and actually this time round I did see her for my very first appointment and she recognised me. She's like "I have seen you before haven't I? You've had another baby?"...It, it just did make me feel (laughs) "she remembers me"....

[Laura-mother of two children]

This relationship is one that exists far beyond the pregnancy and birth. Its importance for Laura is clearly seen in relation to the fact that the midwife offers her the support that she would normally expect from her own mother. However as her own mother lives far away, the midwife offers her the care that enables her to feel empowered to ask questions whenever they arise. When she attends the clinic at the beginning of her second pregnancy, the fact that the midwife recognises her signifies the depth of the relationship between them. When the midwife informs her at the first antenatal appointment at the beginning of her second pregnancy that she is retiring, this has a negative effect on the relationship that Laura subsequently develops with the new midwife. The reduction of visits is perceived as a barrier to the development of a relationship with the subsequent midwife, and does not seem to encourage the depth of relationship and level of social support that Laura requires:

...it was quite nice just to have someone who'd just chat and talk...about any worries. Whereas this time I just haven't felt, and also again, quite a while between appointments, if there's something that's bothered you a month ago by the time you get to your next appointment you've probably forgotten all about it and you forget to ask about it.

[Laura-mother of two children]

In Laura's account the midwife during her second pregnancy does not instil in her the sense of trust and comfort which she developed, from the midwife in her first pregnancy.

The fact that Laura found some similarities between the midwife and her mother, suggest that the midwife became a surrogate mother for her, meeting her needs for support and nurturing which she could not obtain from her own mother. It is important to suggest that the depth of the relationship in some cases like Laura's can create a 'disempowering sense of dependency' (McCourt and Stevens 2009) for mothers, in which they become reliant on the midwife who assumes a power position that woman-centred care is expected to reduce.

During her second pregnancy, Laura does not feel empowered to contact the midwife in-between visits to ask questions:

This time round I felt that I'm just really another appointment...The appointment times were shorter so she feels that she's under pressure to get everybody in and out.

[Laura-mother of two children]

Her perspective of the midwife during the second pregnancy is very different and highlights the fact that her need for support and maternal nurturing is not offered. As a result she does not feel that the midwife places any great importance on her and her pregnancy, since the appointments are so short and infrequent, she does not feel as valued. She considers that the focus does not appear to be on her but rather on the ability of the midwife to get through the clinic.

Fiona, a mother of twins, also experiences the feeling of being an inconvenience. She develops a good relationship with one midwife at the health centre but finds the approach and attitude of another quite brusque, which influences her engagement with the midwife:

I had the appointment booked to see the midwife and then the appointment came through to see the consultant within a couple of days, and she said, "Oh well you needn't have come, you know, if you are going to see the consultant", and made me feel a bit like I was wasting her time though I didn't know that I needn't have gone to that appointment if I was going to the hospital and I did feel that she sort of rushed me a bit, ...I didn't obviously know at all and so subsequently every time I rang up to make a midwife appointment I said, "Oh well, you know, is she definitely there, she is not on holiday, its not going to be the other one is it?", (nervous laugh) because she didn't make me feel like, I think there were a few questions that I wanted to ask but then I probably didn't because I didn't feel that she was giving me the time and didn't want to be hassled with me.

[Fiona-mother of twins]

The unfortunate scheduling of appointments following her referral to the obstetric consultant because of a twin pregnancy, results in an unnecessary visit to the midwife. Although Fiona is unaware of this, she feels humiliated by the midwife's response. As a healthcare professional, Fiona needs the support of the midwife in relation to the

practical aspects of being pregnant with a twin pregnancy, to balance the technical obstetric discussion she has with the obstetrician. As a result Fiona adopts an approach in which she checks with the health centre which midwife is taking the clinic before making an appointment. This approach enables her to avoid the uncomfortable encounters in which she feels a nuisance. Her management of the situation in this way also ensures that she sees the midwife who gives her the time to discuss her concerns and empowers her to ask any questions about her pregnancy.

To summarise the discussion thus far, some mothers within this research consider that a trusting relationship with the midwife is important to enable them to feel the focus of care. Whether there is a personal connection between the mother and midwife or not, mothers value the extent to which midwives make themselves accessible outside the planned antenatal appointments to provide the information and support to address their anxieties. For some mothers however, the depth of the relationship goes beyond a professional friendship and becomes problematic when the midwife is relied upon too much to meet the individual needs of mothers.

THE PROVISION OF SUPPORT DURING LABOUR

Within this discussion I focus on two key issues in relation to support of mothers in labour. The first relates to how mothers value the support of midwives during labour and how their expectation of support is challenged by the negative media coverage of the shortage of midwives. The second relates to the provision of support for male partners and centres on how the midwife's care of the partner can have a positive effect on the mother.

Care during labour is considered in terms of the support provided by the midwife as a professional caregiver. Simkin (2002: 721) defines supportive care as:

nonmedical care that is intended to ease a woman's anxiety, discomfort, loneliness, or exhaustion, to help her draw on her own strengths, and to ensure that her needs and wishes are known and respected. It includes physical comforting measures, emotional support, information and instruction, advocacy, and support for the partner.

Midwifery care in this context also embraces the midwife's skills in assessment and management, underpinned by knowledge and understanding of labour as a physiological process and therefore reflects the midwife's competence. In this context I suggest that the care provided by the midwife in labour encompasses both 'being with' and 'doing for'.

Although the majority of mothers in this study planned to birth their babies in the hospital, Mary is the only mother who planned a home birth for the birth of her first child. At forty-one weeks gestation however, she is admitted for an induction of labour for post maturity and a subsequent hospital birth. Birthing her baby in hospital is not the first choice for Mary and as such the hospital is an unknown and threatening space. The fact that she is unable to birth at home is a great disappointment to her, as she has reservations about birthing in hospital due to her understanding of the level of technology and intervention used compared to a home birth. Once she has accepted the idea of an induction of labour, the idea of going into hospital raises a number of fears:

I think my biggest fear was, I think being left alone, there not being people there to help, you know, like if I wanted support, if I wanted, you know, they would be nobody to ask and I would just be left alone in this room, you know, just get on with it....

[Mary-mother of one child]

Her account of the maternity environment in this context embodies a state of uncertainty. She fears being left alone in labour without the support or help of a midwife. Whilst her fears were not realised, her account emphasises the importance of the midwife as carer is clearly articulated here, and embodies the caring process of 'being with' (Swanson 1991), in which the midwife is emotionally open to the experience of the mother in labour. The support offered during labour is crucial due to the discomfort of uterine contractions. This support encompasses the physical aspects of care described as 'doing for' which addresses issues of physical comfort, dignity, and the competence and skills of the midwife. Mary's account emphasises that the relationship between the mother and the midwife is central to the labour and birth experience for mothers. Being kept informed and having someone present to ask questions are key aspects of this relationship. The possible lack of support from midwives and the resulting helplessness brought on by the lack of facilities like a bed is palpable in her account. The fear of being in pain without the support of a midwife, someone to reassure her of the progress of labour, is a real fear. The image of being left alone in labour conjures up a very distressing and disturbing impression of hospital birth for Mary and also disrupts the perception of the midwife's identity as carer. This raises an overwhelming fear of abandonment for her, at a time when a midwife's support is important in guiding and supporting her through labour. Mary's fear of the lack of midwifery support during a hospital birth is in contrast to the continued support she expects from a midwife at a home birth. This highlights the

importance placed on the presence of a midwife, knowledgeable and skilled in the support of mothers through labour wherever the location of birth.

Dawn, a first time mother, also reflects on this aspect of being left alone without the continuous support of a midwife. Her account describes the situation where she is placed in a side room on an antenatal ward in early labour, as the labour ward is busy and the midwife is caring for more than one mother:

I think part of the midwives job is to calm you down or talk you through it and make sure that you are aware of what's going to happen and, you know, just, well yes, just be nice and sort of talk you through it I think is a major thing rather than being left on your own and kind of, you know, crossing your fingers and stuff, and hoping that you know what's going on. So yes, I suppose it's a by-product of people being busy which is a shame.

[Dawn-mother of one child]

The inconsistent attention of the midwife creates some tensions in relation to the level of communication and support she receives during the initial part of her admission to hospital in labour. She feels neglected when she does not see a midwife for some time due to the busyness of the labour ward and has little idea of how she is progressing. Her ability to cope with the contractions of labour is strained by the lack of midwife support, which she feels is a major part of the midwife's work.

Moreover, for some mothers like Megan, a mother of two children, the busyness of the labour ward and the lack of one to one care, has devastating effects on her experience of labour and her ability to cope with the pain:

I mean the only thing that I would have changed would have been with the fact that the midwife that was looking after me when I was having Carly, she had three other ladies to attend to that night on her own so that is obviously where the problem came in with the gas and air and whatnot, she couldn't get to me quick enough because she had other things to attend to... Because I was doing quite well up until then and it just sort of hit me like a hammer, as soon as I didn't have any pain relief it was just awful.

[Megan-mother of two children]

Here Megan, a mother of two children, is aware of the environment on the labour ward; whilst the support of the midwife is not required in the early stages of labour when she is supported by her partner, when pain relief is required the midwife is unable to bring her the portable 'gas and air' in time and the resulting pain is 'unbearable.' This incident changes the nature of Megan's birth experience, which leads to further pain relief and intervention and a feeling of being out of control. Megan suggests that this is something that she would have changed and is not something that she would have anticipated.

Emily, a mother of one child, also considers the thought of being left alone in hospital with some intrepidation. She planned a hospital birth but as her baby is presenting in a breech position in the third trimester of pregnancy, it is decided in conjunction with the obstetrician that an elective caesarean section is to be the delivery method:

...one of the things I was more worried about that was going into hospital and them being so busy that you didn't have a bed, that you didn't have a midwife, that you didn't see anybody and you were a bit left to your own devices. And I think now people just assume that midwives are so overworked and also perhaps my opinion was a little bit tainted before because of other people's not so lucky experiences because they are so overstretched that you perhaps, I didn't expect an awful lot of help from them.

[Emily-mother of one child]

Although Emily's expectations of labour care in hospital is not realised due to the decision to proceed to an elective caesarean section, her expectations of the provision of postnatal midwifery care however is guided by the perception that midwives are too busy and overstretched to provide the appropriate and adequate level of support for mothers. This view is also influenced by her friends' experiences of labour and birth. For Emily this is particularly worrying because she knows that following a caesarean section she will require additional care. Feeling alone amongst the busyness of the maternity ward also raises issues of abandonment and rejection at a time when support is needed. Although their general evaluation of their care is positive, both Mary and Emily describe their expectations of limited support around birth, where their overall expectations of the service as first time mothers is not very high.

Although mothers evaluate their experiences as generally positive, some mothers describe situations where midwives have limited engagement with them and as a result the communication is poor. The busy environment of the labour and postnatal wards and the demands on midwives also has implications for their communication with mothers. Belinda, a mother of two children born by caesarean section, describes the potential isolation and the feeling of being in limbo created by the lack of communication within the busy environment:

...sometimes when they are busy and you just want someone to just let you know what's happening, it's not that you want people to be there all the time just looking after you but if they communicate and say "we've haven't forgotten, we are doing this and we just need to do this first" I think that is vital because I think sometimes you can feel really alone in it all and not sure what's happening....

[Belinda-mother of two children]

She is clear that having a midwife present continuously may not be necessary and she also accepts the fact that the labour ward and postnatal wards may be busy; however

Belinda highlights the importance of mothers being informed of situations. Her account emphasises the negative aspects of poor communication when mothers are not kept informed and as a consequence do not feel active members in their care. She suggests that a consistent level of communication can avoid the feeling of uncertainty and doubt associated with the busy environment.

These accounts clearly demonstrate how mothers value the midwife's care during labour and the emotions that result when the attendance of a midwife is doubted. From these accounts, mothers anticipate that the care provided by the midwife will reflect what I argue is 'presence' defined as an emotional and relational concept that reflects Swanson's (1991) process of 'being with'. To provide supportive care as defined earlier in this chapter, the midwife must engage with the mother on an emotional and relational basis. Studies have reported that labour support reduces the need for analgesia and that support has a positive effect on birth outcomes (Hodnett, 2002). When the midwife fails to do so, the mother experiences labour as a painful and disappointing experience. Halldorsdottir and Karlsdottir (1996) consider the experiences of women in relation to caring and uncaring midwives. Caring midwives were described as communicative, focused on the woman and supportive; the uncaring midwife was distant, followed routines, emotionally disconnected and cold. Eliasson, Kainz and von Post (2008) also report the uncaring actions of midwives as humiliating behaviours resulting in the loss of dignity. Therefore the effect of the lack of midwife's support is clearly articulated in terms of the negative appraisal of the labour and birth experience.

Supporting male partners

The absence of men within the interviews reflects my original intention to explore identity and gender in relation to the involvement of women around reproduction and birth. Practical issues discussed earlier in Chapter 3 of this thesis, illustrate the complexities of interviewing husbands, partners and male midwives, and provides additional justification for the decision to focus on the relationships between women. However, the following discussion highlights the significance of the relationship between the midwife and the male partner in labour and illustrates the extent to which the midwife can facilitate men's involvement in the birth process; the effect of this facilitation is heard through the accounts of the mothers interviewed.

Although the relationship with their male partners was not an original focus of the research, at times during the interviews, I asked midwives and mothers to provide some clarification in response to what they told me about the involvement of their male partners during labour and birth. It is important to note that I did not ask any members of the study groups to describe their partners' involvement directly. This I argue is significant in itself as the mention of partners' involvement may signify their importance within each woman's individual reproductive biography. As a result, some midwives and mothers did not describe the involvement of their partners in as much detail as others. Since the study group of mothers generated most of the data in this area, the accounts of three mothers will be considered as the primary focus of the discussion in this part of the chapter.

Mothers' expectations of the role played by men during pregnancy and childbirth are very similar. Whilst this may not be surprising, each account however is placed within the unique birthing experience of the mother and her relationship with her male partner and the midwife. Whilst mothers recognise that their partners require a role in labour in order to ultimately support them through the experience, each consider the midwife to have a part to play in facilitating this. What is particularly significant in all three accounts is the effect on this facilitation on the emotional involvement of the male partner and the subsequent effect of this on the mother. For example, studies have suggested that the presence of partners during labour is of benefit to the mother as it reduces the amount of pain experienced and the amount of analgesia required (Henneborn and Cogan 1975; Chopstick et al., 1986). Mothers recount their conversations with and observations of their male partners during labour and the overwhelming influence of the midwife on the partner and the mothers' evaluation of her birth experience. Recounting her first experience of labour, Angela describes how important it is to her that her husband has a role to play:

I think the first time he felt he was just there and he didn't know how to be and nothing can prepare a man for that experience.

[Angela-mother of two children]

Here she identifies Mike's presence as problematic on the grounds that he is unsure of his role. Whilst they both had attended antenatal classes she acknowledges that the reality for him as a man is quite different, since the process of labour and birth is an unknown experience for the male observer. His presence is marginalized and excluded from the birth of his child. The focus on woman-centred care may explain to an extent why some fathers' experiences of feeling 'left out' and of feeling 'in the way,' as they are

not the primary focus of the midwife's care. Angela describes her anxiety and fear for her partner Mike. She acknowledges the difficulty for him of seeing her in pain for the first time and not being able to help. She describes him as a victim traumatised by the exposure to what is a normal event but as he is excluded from it, he is not supported or encouraged to share the experience. Studies have reported how fathers feel very anxious about seeing their partners in pain (Nichols 1993; Somers-Smith 1999). The midwife in this case does not encourage Mike's inclusion in the experience and to an extent focuses her attention on Angela and in the supervision of the student allocated to her. Angela is particularly protective of her partner's presence and whilst she is resigned to the experience of birth herself as a woman, she views this experience as potentially distressing for him. Conscious of her needs and her expectations of him to support her, she expresses her frustration by his inadequacy and by his position in the corner of the labour room:

...Sometimes it's worse to see the person you love in pain and they often get forgotten, your birthing partner or, and I remember several times looking at him and I was worried about Mike, I was thinking 'you know you look so like shell shocked'. He didn't know how to be, one minute I was shouting at him, the next minute I'm saying "hold my hand" and I think the first time he was just there in the corner, he felt a bit in the way....

[Angela-mother of two children]

In contrast to the experience during the labour and birth of her first child, Angela describes her partner's presence during the birth of her second child in a more positive way. Although she describes the first experience as 'good' in terms of its outcome, her emphasis within her account focuses on their newly found joint confidence:

...the second time he was actively part of the delivery really, although he didn't want to go down that end at all (laughs), he gave me lots of support and the Midwife really spoke to him and they were chatting and they were actually forming a relationship as well and it was Mike that actually said to me "make sure you get Mary a card", you know "to say thank you" because she had you know, an impact on him....

[Angela-mother of two children]

Here Mike, her partner assumes more of a supportive role facilitated by the midwife. She describes his inclusion within the birth and the communication between him and the midwife. The midwife actively engages both Mike and Angela, and through this, acknowledges his part in the birthing process. His appreciation of this process of inclusion is clearly shown in his request for a thank you card.

The significance of the midwife in facilitating partners' inclusion is key to the mothers' evaluation of the partners' involvement and the level of support provided. Dawn and Tim's experience draws on similar issues. Having waited in the admission room for a short

while, Dawn describes how Tim her partner, was unable to help when she was eventually moved to a room for an initial assessment. At this point, based on the assessment the midwife explains that she could go home. Dawn refuses and the midwife offers her some oral analgesia and suggests that she go to the ward for a while:

...I knew my kind of level of pain threshold was breaking...she said "you can have some Paracetamol" like that's not going to touch me.

[Dawn-mother of one child]

This is unsettling for Dawn, as she perceives that due to the busyness of the unit, there was nobody there to help or provide adequate pain relief. This results in Tim's feeling of helplessness and vulnerability. Here too Dawn describes her partner's inability to assert control over the situation and lessen the pain experienced. His need to protect Dawn is clear here but his ability to provide support is inhibited:

...I think it made Tim feel very out of control because not only was I in pain but the people that were there to help me weren't seemingly helping me kind of thing, and he couldn't really do anything about it. He didn't know what he could do to sort of make the situation better. Like with me, it was kind of like, I am lying on a bed and I just want to get it over with.

[Dawn-mother of one child]

Dawn's frustration is clearly articulated as she describes Tim's inability to support her and improve the situation when she is exasperated with the whole process and wishes it was over. Following this initial experience, she recalls how Tim is encouraged to participate by a different midwife on the change of shift and the eventual transfer back to the labour ward:

...because he was able to ask her questions and, you know, she was willing to just sit and, you know, talk to him and, yes, definitely. He felt more in control and she was suggesting, like do you want to try it on all fours and see if that's better and quicker, you know, might help it and yes, that sort of thing did I think...again he could just sort of looked after me then and know that I was kind of being cared for that end...so I think he did feel a lot better at that point.

[Dawn-mother of one child]

As soon as Dawn is settled into a labour room, Tim's role becomes clear and more established, facilitated by the midwife. The issue of control here is interesting as it highlights the fact that the presence of the midwife in charge of 'that end' facilitates his own sense of being in control of not only his own emotional state but also in providing physical care. The midwife facilitates his inclusion and participation within the process, which Dawn describes in relation to the second stage:

...I was at the pushing stage so she [the midwife] was talking me through it and giving me advice on how to push and stuff, and chatting to Tim and me all the way through it....

[Dawn-mother of one child]

In situations when the midwife does not facilitate choice and control through communication, or through the inclusion of either the mother or partner, the experience of birth is very negative. Belinda in her experience of hearing that her baby is to be delivered by emergency caesarean section describes a situation in which she feels very unsupported and isolated:

...a bit of a shock and because they hadn't talked it through until, "right we are going to do it" you know, it's frightening, it's really scary and if you haven't got that support of someone who knows that knows what they are doing, it's even more frightening because you are hoping, my husband didn't have a clue, and it is kind of me, him and the Midwife who hadn't really talked at all during the time of my labour or bothered to establish a relationship or rapport with me.

[Belinda-mother of two children]

In the absence of any rapport with the midwife, the decision to perform a caesarean section is unexpected. As the midwife has not alerted Belinda to the possibility of this decision, she feels not only unsupported but also fearful of what this might mean. Having had no preparation or reassurance that all would be well, she feels isolated and alone. She recognises that the midwife as a knowledgeable practitioner has provided her with little if no information and therefore she has little expectation of support from her male partner who has no knowledge either. Belinda feels disappointed and betrayed by the midwife who is in a position to support her and prepare her for birth, but has made no attempt to talk to her or build any kind of relationship with her. Her partner in contrast has had a limited role and is unable to support Belinda, as he has not been informed of the situation.

These accounts illustrate how mothers in this research depend on their male partners to provide support during labour, but based on this data, fulfilling this role is dependent on how the midwife can facilitate their involvement. Bartels (1999:683) writes: 'midwives need to be sensitive to the needs of these men. A midwife's empathy, sensitivity and support towards the father is essential.' Although there appears to be limited data on how midwives support male partners during labour (Mander 2004), some argue that midwives should be sensitive to the needs of fathers (Rosich-Medina and Shetty 2007). Since the involvement of men has been reported to have a positive benefit on the experience of labour and outcomes at birth (Bartels 1999), my data supports the involvement of the male partner in labour to enable the birth experience to be as positive as possible for the mother. The data also illustrates how the lack of involvement can be a

source of stress for both mothers and their male birth partners, illustrating that it could be another form of emotion work for mothers.

FACILITATING POSTNATAL CARE

Midwives who work in a hospital setting provide postnatal care for the mother and baby during the first few days after birth until they return home. Assisted by support workers, midwives monitor the health and well being of both the mother and baby by undertaking a daily examination; being available to help the mother with feeding the baby, and being at hand to provide support and education.

Mothers' accounts of care received in hospital centre on examples of good care where the midwife enables mothers to gain confidence in their role as mothers, incorporating a sense of faith in the mothers ability. However, in some of the encounters with midwives, the needs of the mothers are not met. These accounts resonate with the observations of Dykes (2006). In her ethnographic study of breastfeeding in hospital, she observed a number of encounters that resemble what Fenwick, Barclay and Schmied (2000) describe as inhibitive and facilitative nursing action. In the context of the data analysed in this study, the work of Fenwick, Barclay and Schmied (2000) is equally significant in relation to the midwife's identity as carer. Actions which included nurses directing care and dismissing the woman's skills was considered as inhibitive, while facilitative action included encouraging and was based on working with the mother.

The aim of postnatal care is to instil confidence in the mother's ability to care for her baby, and to provide physical, emotional and social support in the transition to motherhood. In this context, care provided by the midwife within the postnatal period should encompass all these aspects. Belinda in her account of how a midwife helped her to breastfeed the first night following her caesarean section, describes how the midwife's positive comments are encouraging and empowering even though she has limited movement following a spinal anaesthetic:

...she[midwife] was very encouraging because she [baby girl] was feeding a lot even at that point. The Midwife kept saying "oh she's a good girl isn't she, she's really feeding well" and that was nice, because it just made you feel like 'I'm doing a good job here, even though I can't move, I'm still looking after my baby to the best of my ability' you know, the hours after she'd been born....

[Belinda-mother of two children]

The midwife makes Belinda feel that she is caring for her baby like all the other mothers although she requires some help until she regains movement in her legs. In a similar situation, Jessica's account reflects her appreciation of the level of care provided following a long and difficult labour, which results in an emergency caesarean section. Recognising the fatigue and exhaustion experienced by mothers following a prolonged labour and caesarean section (Nystedt, Hogberg and Lundman 2008), the sensitive approach of the midwife is an acknowledgement of the difficulty Jessica has experienced and the fact that she is unable to care for her self at this time. She describes the care as 'supportive' and 'natural' whereby care is not considered to be a number of tasks but a compassionate attempt to make her feel more comfortable following her difficult labour:

I felt very cared for particularly with having had David because I think they knew that I had had a bit of a difficult time of it and they were very supportive and looked after me, you know, gave me the bed bath and didn't mind that suddenly someone was stripping me off and washing me, it was just so natural and made you feel that they were there because they wanted to be and they wanted to look after you and make sure that you were OK and if that meant washing you and helping you breastfeed then that was what they were going to do.

[Jessica-mother of two children]

The care described here reflects many of the processes described by Swanson (1991), that illustrates the fact that care can encompass different dimensions, and demonstrate the identity of the midwife as carer.

Eloise, a mother of two children, appreciates the help and support from the midwives on the postnatal ward following her second caesarean section. She considers that continuity of carer is more important following the birth of a first baby and her account highlights the fact that she requires less supportive care following the birth of her second child. Nevertheless when she requires the midwife's assistance with the practical aspects of lifting the baby out of the cot for breastfeeding, the support is there:

...I didn't see as much of the midwives this time around but I don't think I needed to in some ways. I mean they, you know, when I first arrived on the ward, you know, the midwife actually said to me she said, "we tend to operate a policy of you call if you need us", which she actually explained up front, you know, "we are not going to be hovering over you. You call us if you need us". And to be fair, that first sort of night...I still had my, the first night I still had my...catheter and everything in so I couldn't physically lift him in and out of the cot, I would just buzz and somebody would come and lift him out for me and things like that. So you know, the support at the hospital was good although I saw a different midwife every shift I think because of the way they, I never saw the, I don't think I ever saw the same midwife whereas I remember in with Tabitha...there was one midwife who would always be there on the night shift and we got quite a good relationship going.

[Eloise-mother of two children]

This practical support is important to her at a time when she is immobilised due to the spinal anaesthetic and the addition of a urinary catheter. The midwife's actions enable her to care for her baby and resume breastfeeding.

Midwifery care should empower mothers to become competent and confident mothers. However, mothers describe some experiences in which their interactions with midwives leave them feeling belittled and disempowered. In these situations, mothers find ways to limit the personal interaction with midwives by segregating themselves. One such example is the experience of Megan. Following the birth of her second child, which was small for gestational age, Megan describes the situation on the postnatal ward:

I started getting sort of, getting a bit bitched at in the hospital so I just tended to keep myself to myself actually (nervous laugh)...Well it was, they told me I had to wake her up every three hours for a feed and it was hard to wake her up and I couldn't get her awake and they kept saying "oh, you have been trying for like you know, 20 minutes now, you should have come and told us." Well 20 minutes I didn't think was a great deal of time to be fair and they couldn't wake her up in any case when they tried so you know, I just felt that they were getting at me, it was just the griping while I had visitors and stuff like that, you know, coming along and telling me off like I was a naughty schoolgirl while I had visitors there and stuff and it was just, yes, that soured the experience a bit to be fair but it was only for the last couple of days that I was in hospital, up until then it was fine.

[Megan-mother of two children]

The midwives' concern for the baby is perceived as a personal attack on her ability to follow the 3 hourly regime of feeding. This concentrated attention on feeding is not communicated or considered as supportive individualised care but in contrast makes Megan feel persecuted and hopeless. This is particularly distressing for her when she is criticised in front of her visitors. This is especially alarming as this is Megan's second baby following a gap of fourteen years. The midwives' approach is perceived as unhelpful and the level of communication is inadequate as Megan is not empowered to consider the relevance of this action for her baby and cannot understand the midwives' concern. It also derides her previous experience as a mother and whilst she acknowledges the fact that there is a large age gap between the births of her children, the midwife does not instil a sense of confidence in her ability to care for her baby.

Another example is Jessica's experience:

...'why are you wasting my time, coming all the way down here' so I never, ever, ever rang my bell on my bed ever again because I thought 'I don't want to put them out, they are obviously really busy, they don't need me ringing when it is not really, you know, it is not urgent' and having had the caesarean I could hardly get out of bed but I am not ringing my bell because I might, you know, might upset somebody so I carried on trying to get myself

up and out of bed and being really uncomfortable and that was because of that one experience with that midwife being so abrupt.

[Jessica-mother of two children]

Following the birth of her second baby by elective caesarean section, Jessica describes a situation where she has rung the bell to ask for help to get out of bed. The midwife's response to her call is negative and unhelpful suggesting that Jessica is wasting her time; for Jessica this is distressing. In this situation, the physical care of helping a mother who has sustained major abdominal surgery (in this case a caesarean section), is considered as unnecessary and a waste of the midwife's time. Her fear of 'upsetting' someone reflects an environment in which she does not consider herself to be the focus of care and results in her reluctance to call for further help as this removes the midwife from more important tasks. Even in this situation, Jessica is supportive of the midwives to some extent, even suggesting that as they are busy her needs are not important enough to warrant calling a midwife to help her and are petty in comparison to others. As an alternative, the pain and discomfort of getting out of bed unaided is therefore considered to be an acceptable part of her recovery. The midwife's response is disempowering and makes Jessica feel inadequate and incompetent. In this account the midwife's response does not convey the caring identity that one would expect of a midwife. The balance of power illustrated by this account is firmly held by the midwife, whose actions reflect an environment in which mothers are not considered the focus of care.

The view of postnatal care illustrates the inconsistent approach of midwives to the care of mothers. Whilst I would argue that some of the care could be described as exemplary, other accounts in this research reflect a picture where some physically vulnerable mothers do not receive appropriate care after caesarean section. The nature of uncaring encounters described in this research could be considered in terms of the issue of lack of time to care and, secondly, reflect the uncaring attitudes of midwives; both of which could be regarded as symptoms of the organisation of postnatal care within the constraints of institutional policy and practice. The lack of time to care has been previously discussed (Dykes 2006); contemporary literature on the provision of postnatal care reveals that postnatal care remains the Cinderella service, which is a highly neglected area within childbearing. Successive reports have highlighted that mothers are dissatisfied with the provision of postnatal care across the UK and also Australia (Audit Commission, 1997; Garcia, et al., 1998; Singh and Newburn, 2001; Beake, et al., 2005; Wray 2006). Researchers have also started to describe uncaring encounters with

midwives (Halldorsdottir and Karlsdottir 1996; Eliasson, Kainz and von Post 2008), concluding that midwives have lost their caring attitude; an explanation for the uncaring attitude has not been forthcoming.

However, what is clear is that mothers are reluctant to complain about inadequate postnatal care illustrated in some of these accounts. Whilst mothers describe the busy environment of the labour and postnatal wards, they remain supportive and protective of the midwives, placing the blame on the organisation of maternity services rather than the attitude and behaviour of individual midwives for the lack of midwifery time. One such example involves Jessica. Following her second caesarean section, Jessica, describes the hospital environment as a chaotic place, in which midwives communicate the busyness of the ward by their physical actions of rushing around the ward:

I think I would say that you don't get as much one to one care as I would have expected just initially, with Samuel when he was born, always so busy, the ward I was on was so busy, you know, I had left my door open and you just see midwives run, you know, running up and down the corridor interacting with all the different women and all the different babies, I had no idea that it was such a pressured job, I thought that there would be more midwives, the ratio midwives to mothers would be a lot higher and that is not a reflection on the midwives I don't think for one minute, it is a reflection on the situation that we are in....

[Jessica-mother of two children]

This highlights the fact that in contrast to the idea of individualised care, midwives prioritise care, which affects the provision of care that some mothers receive:

I mean when I had Samuel, the midwife said to me "right, go and have a shower and get your, you know, your thingy (dressing) all wet and we will take it off for you and we will have a look at your wound, come back and let me know when you are out of the shower" and I did that, two and a half hours later I had to go down and find her and bless her, she hadn't stopped, it wasn't that she was sitting down thinking 'I can't be bothered', she hadn't stopped and I felt so awful going to her and saying "look I am really sorry but I have been sitting with a wet bandage on my wound for ages, can you come?" "Oh" she said "I am so sorry, I am on my way now" you know, and I just felt sorry for her really because I know that she would have come two hours earlier but she just didn't have the time. So I would say that is the one thing that surprised me is that when you are on the ward there aren't more midwives around.

[Jessica-mother of two children]

When the midwife has forgotten to check her wound following a shower and remove her damp wound dressing she makes the distinction between midwives who are busy and those who display a poor attitude. Here Jessica is protective of the midwife and justifies the fact that she has been waiting for the midwife to return to her.

In contrast, the effect of the lack of midwifery time is clearly articulated in Mary's description of how midwives did not have the time to sit with her and support her in

breastfeeding. At this point both Mary and Jessica justify the lack of care and support they receive, by describing the workload of the ward and the shortage of midwives. They also acknowledge that their needs as mothers are prioritised and that there are more deserving mothers with more severe problems that require midwives' time. Mary's experience of breastfeeding is an example of how mothers blame the busy environment for the lack of midwifery support and the demands of more needy mothers on the time of the midwife. However, her account reinforces the need to support mothers with breastfeeding on the postnatal wards, as Mary feels that she no alternative but to bottle-feed her baby:

I think they were so busy they couldn't, you know, she didn't have time to sort of sit with me properly and like I say, she didn't sort of latch on properly and in the end I gave her a bottle and they said 'Oh, we would like you to stay in' but then again obviously I know it is not their fault, they wanted me to stay in but like I say I was there at one point for six hours and not one midwife came up or saw me or came near me basically because obviously they are dealing with people I suppose that have got problems or are coming to them because like she said, the lady said to me, there was one midwife for fourteen mothers on the ward and one healthcare assistant for obviously fourteen babies, so they had got two people looking after twenty eight people and they didn't, they just didn't have time.

[Mary-mother of one child]

The emphasis on the ratio of staff to mothers and babies on the ward is clearly articulated here and reflects the fact that the busyness of the ward is a subject of discussion amongst mothers. As Dykes (2006:128) states: 'midwives communicated a powerful sense of urgency that led to rushed and disconnected communication.' Because of the awareness of the postnatal environment, mothers like Jessica and Mary feel that they must do as much for themselves as possible. Reflecting on her study of postnatal care in hospital, Wray (2006:524) notes a similar situation:

During the observations, mothers spent a substantial amount of time alone with their babies. Acquiring help from, and interacting with staff generally had to be instigated by the mother by ringing the patient call bell. For many mothers this posed a dichotomy between their genuine need for help and assistance, and the thought that they were diverting staff from duties and workloads. Mothers spent long amounts of time deliberating as to whether the call for help was worth it and whether staff would form the same judgment as to the worthiness.

Although the majority of mothers praised the community services they received, in an evaluation of community postnatal care during her second pregnancy, Belinda described the reduction in postnatal visits as:

Resource - led rather than kind of what women want

[Belinda-mother of two children]

This discussion raises two main issues for further consideration. Firstly, the focus on the relationship between care and time is an important one and has been previously described in relation to midwifery care (Dykes 2006). Deery (2008:344) also notes that partnership working between midwives and mothers is 'bound by clock time culture through organizational demands to meet targets and rationalize services.' Moreover the accounts within this chapter highlight the conflict between the lack of relational time and clock time. Secondly, all these accounts reflect mothers' support for midwives in the face of resource changes in the maternity services. I argue here that whilst some mothers may have received inadequate care, their accounts illustrate their support for midwives. In this context I suggest that mothers may view midwives as an oppressed group of carers (Kirkham and Stapleton 2001). On the basis of the data presented I suggest that by communicating busyness to mothers in both verbal and behavioural terms, midwives not only inform mothers of the level of care to be expected but it inadvertently acts to protect themselves from criticism. In this context I suggest that midwives may perpetuate their identity as an oppressed group as a means of gaining empathy from mothers when difficult circumstances arise. Moreover, Dykes (2006:129) suggests that even when the ward area is quiet, midwives continued to promote a 'busy mode'. Whether the uncaring encounters and poor attitude described here by some mothers may be symptomatic of oppressed group behaviour (Roberts, DeMarco and Griffin 2009), is inconclusive.

CONCLUSION

Within this chapter, the identity of the midwife as carer has been explored in relation to the experiences of mothers. The nature of caring encounters reveals the complex and conflicting nature of the relationship between mothers and midwives within the current maternity services. Where partnership exists, the facilitation of the philosophy of woman-centred care is evident, in which mothers feel the focus of care and in control of decisions taken. This results in a meaningful relationship for both midwives and mothers, in which mothers value access to the midwife and the information and support provided. The implications of the midwife's attitude in labour are clearly articulated in the accounts. Mothers and partners value the midwife's caring attitude and support in labour; where this does not take place, both mothers and their male partners feel isolated and vulnerable. Some of the accounts discussed in this chapter demonstrate how midwives provide supportive care for mothers that encompasses the processes proposed by Swanson's (1991) theory of caring; however the attitude and approach of the midwife

and the organisation of services influence the provision of care and the perception of care received.

This chapter has illustrated how partnership working is an integral part of antenatal services in the community but rarely considered in the hospital setting for labour and postnatal care due to the lack of time and workforce issues. The hospital environment is considered a threatening place as a result of mothers' awareness of the crisis within the maternity services. A lack of midwifery time is a consistent thread throughout the accounts, which is a major influence on the provision of care. Whether the uncaring attitudes and action of some midwives described in this chapter can be explained by the idea that mothers consider midwives to be an oppressed group is unclear. However mothers remain supportive of midwives even though specific accounts highlight significant deficiencies. They become very defensive of midwives, blaming the system for the situation rather than individual midwives for uncaring actions, in which their care needs are not met. Some mothers identified that midwives prioritised care of other mothers, to an extent that they considered their own needs to be trivial in comparison. Whilst mothers in this research view midwives as key providers of supportive care around birth, the nature of the encounters analysed in this chapter reveal a rather more complex construction of the caring identity of midwives, based on ambivalent and contradictory representation of woman-centred identity. A major influence on the caring identity is the location of care and the constraints imposed by institutional culture. This is evident in mothers' experience of antenatal, labour and postnatal care in terms of contact with the midwife and the time allocated for visiting. The result of this is the perception of the lack of support that limits mothers' appreciation of their experiences. Connected to this is the influence of the midwife's management of emotion that appears to promote the perception of the lack of caring capacity. Where mothers describe midwife's empathetic support, care appears to be focused on the needs of the mother; where the needs of mothers are not met, the approach is rigid and distant.

In the next chapter I bring together the findings of the research in the context of the aims of the study and the research questions. A review of the application of an auto/biographical approach will form a basis of a methodological discussion. Recommendations for policy, practice and future research will be made.

DISCUSSION AND FINAL REFLECTIONS

INTRODUCTION

This thesis has explored gender identity in relation to midwifery and midwifery work, focusing on the relationship between gender, identity and emotion. Specifically it illustrates the complexity involved in the relationship between gender identity and emotion in relation to mothers and midwives. The thesis highlights the distinction between emotion as an aspect of care (Swanson 1991), and the concept of emotion work, defined as the management of emotion (Hochschild 1979; 1983; Hunter 2004a). Whilst Hochschild (1979; 1983) differentiated between emotional labour and emotion work, suggesting that emotional labour was a public display and management of emotion, whereas emotion work was conducted in private; Hunter (2004a) adopted the term emotion work within midwifery (Hunter 2004a). For the purpose of this thesis, I adopted the term emotion work as used by Hunter (2004a) to encompass both the public and private expression and management of emotion in relation to midwifery work (Hunter 2004a).

The findings of this research illustrate the implication of emotional care for midwives and mothers, and present insights into situations where the provision of emotional care can become a source of emotion work. The influence of midwives' embodied experiences of childbirth and motherhood are significant within this discussion. For this reason, this thesis makes an original contribution to the understanding of emotion in midwifery work by highlighting the significance of gender identity to the emotional relationship between midwives and mothers, and how this can create different sources of emotion work within midwifery.

In this final chapter I discuss this in two specific ways. First, I consider how the empirical findings highlight the relevance of emotion to the construction of the identity of the midwife and to aspects of midwifery care, as well as being significant to the relationship between midwifery and motherhood. To frame this discussion, it is placed in the context of the original research questions. Second, in using an auto/biographical approach, I highlight the relevance of emotion to auto/biography and the value of this to midwifery

research. I also consider how auto/biography can be a potential source of emotion work for the researcher.

The purpose of this final chapter therefore is to discuss the contribution of this thesis to the existing literature on emotion in midwifery by focusing on the relationship between emotion and gender identity, and drawing on the empirical findings of the research to make recommendations for policy and practice, and further research.

To set the context of the chapter, I begin by discussing the empirical contribution of the thesis by revisiting the original aims and research questions. I have structured the discussion around the research questions to illustrate in more detail how emotion is implicit within the identity of mothers and midwives as women. Within this discussion I re-establish my rationale for the examination of gender identity from the perspective of women, and consider the position of the male midwife. With reference to the contribution of emotion within auto/biographical research, I focus on my journey as a situated researcher and the relationship of auto/biography to emotion. Lastly, I consider the limitations to the research and propose recommendations for policy and practice, as well as recommendations for further research.

AIMS AND RESEARCH QUESTIONS

The purpose of my research was to explore the issue of gender identity in relation to the midwife and midwifery work. Three specific aims were identified. First, to contribute to the theoretical and sociological understanding of gender identity in relation to reproduction, midwifery and motherhood; second, to explore midwives' personal experiences of pregnancy and birth, and how their embodied experiences influence practice; and third, to contribute to the understanding of the 'meaning of motherhood', from the experience of midwives and mothers. As these aims emerged from my embodied experiences of reproduction, midwifery and motherhood, the issue of emotion was implicit in this research in terms of my personal relationship with the subject area and supported by my decision to adopt an auto/biographical approach. Three specific research questions were therefore developed from the exploration of these aims. These questions were:

1. How is the identity of the midwife constructed?

2. Do the reproductive experiences/expectations of midwives influence their practice and the way they care for mothers?

3. How do midwives and mothers view motherhood and mothering in the context of midwifery care and how maternal identities are constituted in this encounter?

I considered gender identity from the perspective of women to be the main focus of this research, since gender identity in midwifery offered the opportunity to examine the essentialist claims that caring occupations were established *vis à vis* the relationship between caring work and femininity (Kent 2000). Furthermore, it enabled me to question the relationship between the contribution of social construction of identity and the essentialist notions that all women share the same attributes to care. This raised the issue of the importance of care around birth and enabled me to question the historical position of women as midwives in the emotional activities of birth and death (Callaghan 2007; MacDonald 2007; Symonds and Hunt 1996). Furthermore, the exploration of gender identity in this context was important since the majority of midwives are women, and for that reason, I was able to examine the relationships between women and the importance of gender around pregnancy and birth.

The following discussion considers the significance of emotion in the context of these research questions and details the contribution made by this thesis to the study of emotion in midwifery work.

THE IDENTITY OF THE MIDWIFE

The findings of this research reveal the complexity in the relationship between gender identity and emotion in relation to the midwife's identity. More specifically, this research provides particular insights into the identity of the midwife as a carer, especially in relation to emotionality.

Drawing on the work of Simkin (2002) and Swanson (1991), the caring encounters described in this research encompassed the features of supportive care which embraced a sense of responsibility; compassion and consideration; where mothers described midwives as wanting to enhance health and well being through support and guidance. Both midwives and mothers expected their caregivers to display a caring attitude; this reflected their emotional connection to mothers and their identities as midwives. Active listening and good verbal and non-verbal communication skills appeared to be accepted

as a reflection of the caring approach of the midwife. Some mothers described emotional engagement as a more physical intimate approach to care; for example, rubbing the mother's back and pouring water over the abdomen. I concluded that emotional engagement within midwifery care was considered as an emotional presence (Wilkins 2000; Thomas 2001; Pembroke and Pembroke 2008), facilitated by acts of compassion, empathy and support (Mander 2001), which encompassed the provision of individualised woman-centred care (DH 1993; Pairman 2000; Carolan and Hodnett 2007). The findings of this research extend the present literature by illustrating how emotional engagement can take place in different ways, and that mothers may not all require the same level of emotional engagement from midwives. Moreover, the caring actions of midwives described in this research suggest that, on balance, they were able to identify the level of emotional engagement required to meet the individual needs of mothers.

Hunter's (2004b) emphasis on the development of emotional intelligence is significant here since it offers a possible explanation for the actions of the midwives in this study. Drawing on the work of Goleman (2005), Hunter and Deery (2009:7) suggest that 'emotionally intelligent people: recognise and manage their own emotions, motivate themselves, recognise the emotions of others and handle relationships in an effective manner.' The findings of my research suggest that the display of emotion within midwifery care may reflect the midwife's ability to manage her emotions within her relationships with mothers, conforming to 'feeling rules' (Hochschild 1979: 563), rather than reflect innate feminine characteristics (Woodward 1997).

However, the nature of the encounters analysed in this thesis revealed a rather more complex construction of the caring identity of some midwives who worked in the hospital setting than that represented by other researchers (Pairman 2000; Mander 2001; Carolan and Hodnett 2007). Many mothers described encounters with midwives that seem to challenge the identity of a carer in this context; midwives appeared to be emotionally disconnected, displaying a rigid, cold and distant attitude which concurred with previous findings (Halldorsdottir and Karlsdottir 1996; Eliasson, Kainz and von Post 2008). These encounters were characterised by a lack of communication, in which midwives were considered to display a poor attitude, associated with a reluctance to support mothers with aspects of physical care and breastfeeding, for example. Whilst I do not intend to make 'excuses' for some of the seemingly deficient care described by some mothers in

this study, I suggest that where emotional engagement was absent, midwives may have found the management of their own emotions as well as identifying the emotional needs of mothers, challenging. Although the research did not explore the possible reasons for the uncaring encounters and the lack of emotional engagement described in this study, it did expose the difference in the experience of hospital and community midwifery care and its implication for emotion work; this was significant in relation to the provision of woman-centred care and to mothers' support of midwives.

The accounts discussed in this thesis reflect an ambivalent and contradictory representation of the woman-centred identity of the midwife, since the poor care described by mothers suggest that some midwives were not focused on their individual needs. This is illustrated in this thesis by the contrast between mothers' experiences of hospital and community care, where the relationship between emotion work and the provision of woman-centred care is inconsistent. The findings of this research suggest that whilst some midwives found it difficult to provide woman-centred care in the hospital, the experiences of mothers receiving care in the community suggest the opposite; partnership working in the community facilitated the philosophy of woman-centred care where mothers felt the focus of care and in control of decisions. This resulted in a meaningful relationship for both midwives and mothers, in which mothers valued access to the midwife and the information and support provided. This finding illustrates that emotion work may not always result in negative experiences for both the midwife and the mother. The emotion work of facilitating woman-centred care in the community may have the opposite effect and may generate a sense of satisfaction for both the midwife and the mother (Bolton 2005). Therefore, on the basis of this research, I suggest that the hospital is a source of emotion work for midwives that creates a negative experience for some midwives and mothers, where the woman-centred identity of midwives is compromised by the environment in which it is set (Kirkham 1999; Leinweber and Rowe 2008). This finding extends the current literature by placing a focus on the relationship between the provision of woman-centred care and what that means to the identity of the midwife as a carer.

Furthermore, the difference in the experience of hospital and community midwifery care supports Hunter's (2004a) work by illustrating the presence of conflicting ideologies which underpin the provision of midwifery care in different locations, and in pointing to

hospital based care as a source of emotion work for midwives. However, whilst the hospital environment is associated with lack of time (Dykes 2006; Deery 2008) and workforce issues (Curtis, Ball and Kirkham 2006b), mothers within this research remained supportive of midwives, even when deficiencies in care were described. This confirms the findings of earlier work (Kirkham and Stapleton 2001) that suggests that midwives may display behaviour that resemble characteristics of an oppressed group (Roberts, DeMarco and Griffin 2009). This is an interesting issue but whether the uncaring attitudes and actions of some midwives described in this thesis can be explained by the idea that midwives are an oppressed group is unclear.

However, what is noteworthy is the implication of the support for midwives in these circumstances. Even when their own care needs were not met, some mothers were reluctant to challenge midwives because they were seen to be prioritising care for others. This implied that mothers viewed midwives as caring even though their own experiences may have been deficient. Although this may suggest that mothers accept that midwifery care will be prioritised within the hospital environment, blaming the system rather than individual midwives; this situation made mothers feel that their own needs were trivial in comparison. I suggest that this is a further example of emotion work, where mothers were left to manage the emotional impact of the lack of care and attention on their own.

The impact of this emotion work on the well being of the mother illuminates the nature of midwifery care in hospitals, and contradicts the philosophy of woman-centred care. Although the relationship between emotion work and women in the workplace is well documented (Hochschild 1983; Hunter 2004a; Bolton 2005), the relationship between mothers and midwives in this context is a new contribution to the literature. The experience of emotion work in this way may add to the emotional and psychological upheaval of mothers' transition to motherhood and may add further stress to an already challenging situation for the mother. This finding provides an insight into the relational aspects of emotion work within reproduction and childbirth, and reveals that emotion work is not limited to midwives but their actions or inactions can create emotion work for mothers.

THE INFLUENCE OF MIDWIVES' EXPERIENCES ON PRACTICE AND CARE

The thesis has illustrated that reproductive identity is central to the gender identity of midwives as women. As stated in Chapter 1, the discussion of identity in relation to women and reproduction centre on the influence of the social construction of gender identity (Woodward 2002) and on the debates around biological essentialism (Grosz 1994). I discussed earlier in this thesis the significant role played by gender in the identity of women (Spelman 1988; Wadsworth and Green 2003), especially in relation to how women view themselves *vis à vis* reproduction and motherhood (Phoenix and Woollett 1991). Gender offers a constant dimension to identity (Järviluoma, Moisala and Vilkkio 2003), but can be problematic since identities are situated, multiple and socially constructed, requiring negotiation and renegotiation (Haynes 2008). This was particularly relevant to the experiences of midwives in this research, since the implication of embodied experiences in the context of multiple identities was shown to present some challenges for midwives, especially in terms of exercising agency.

Whilst Rowan (2003), Bewley (2009) and Battersby (2009) have established the complexity of embodied experience in relation to non-motherhood, infertility and breastfeeding, the findings of this research extend their work to suggest that midwives use their embodied knowledge of pregnancy and birth in different ways in practice. Some midwives within this study were biological and or social mothers, whilst three midwives were non-mothers. Midwives recalled their experiences as pregnant women seeking care and support from their colleagues; others discussed their experiences of caring for their colleagues during pregnancy and birth. Whilst previous work has considered the occupational boundaries within professional relationships in practice (Hunter 2005), this research makes an original contribution by showing how midwives formed and reformed boundaries between their professional identity and their embodied experiences as mothers, as a means of controlling emotion in different situations. Moreover, this had implications for the degree of agency and autonomy exercised in relation to their experiences. In Chapter 5 midwives recognised that working during their pregnancy generated different and sometimes contrasting emotions for midwives and mothers. For example, this was particularly significant in relation to the experiences of a pregnant midwife caring for a woman following a miscarriage on the antenatal ward. Midwives' experiences of traumatic births involving friends or close colleagues illustrated the danger

of blurring the boundaries between professional and personal; the implication of the emotional investment for midwives in the care of mothers, and the impact of unexpected events on their confidence and desire to continue working as midwives following these events. The findings of this research highlight the significance of emotion in mediating the relationship between midwives' experiences and their practice. This was especially important in the context of midwives' identity.

The use of professional knowledge in the exercise of agency and autonomy in decision-making was a source of emotion work for some midwives within this study. Managing their emotions became difficult when their professional identity was overlooked and they were recognised as pregnant women. Their knowledge and understanding of the processes and systems within midwifery enabled them to challenge their caregivers and to negotiate care decisions. They used their knowledge of pregnancy and childbirth to exert their autonomy with caregivers as a means of maintaining their identities as midwives; for example, in discussions about the need for induction of labour and the location of birth. However, certain embodied experiences of pregnancy and birth appeared to generate emotional difficulties for some midwives, challenging their attempts to exercise agency in how they represented themselves (Woodward 2002); and also in terms of maintaining dual identities (Haynes 2008). This was illustrated in Chapter 5 by the challenges of balancing the identities of both mother and midwife. Emotional upheaval experienced following an unexpected pregnancy, for example, led to feelings of denial and isolation; detachment and guilt were specific emotions associated with the transition to motherhood, in this example. These findings extend the margins of earlier studies of emotion work in midwifery (Hunter 2004a; 2004b; 2005; 2006) to include midwives' reproductive experiences. The findings of this research make an original contribution to the understanding of the relationship between emotion, midwives embodied experiences of reproduction, childbirth and motherhood, and the issue of professional identity.

Midwives who were mothers suggested that their experiences had given them insight into pregnancy and childbirth. In these cases, midwives' embodied experiences were considered a means of empathising with mothers and a way of validating mothers' experiences. They considered the use of personal experiences to be helpful in selective cases where it seemed to be useful to the mother; for example, where an epidural was

needed. Indeed, midwives valued their embodied experiences but did not consider the sharing of their experiences to be important unless the mother asked. Their embodied experiences were considered to be more implicit than explicit within midwifery practice. In this context, reproductive and childbirth experiences whilst useful were not necessarily important. I have also shown that they can be unhelpful at times. It is worth concluding that reproductive experiences and expectations do influence practice but not in a uniform way, nor in a way that could be described as either positive or negative. This finding was also significant in relation to the nature and contribution of empathy within midwives relationships with mothers. Swanson's (1991) theory of caring was significant here since she suggests that emotional presence is facilitated through the use of compassion and empathy. However, since gender is central to identity in this research (Järviluoma, Moisala and Vilkkö 2003), female midwives who were non-mothers at the time of the study, considered themselves to be as empathetic as midwives who were mothers, challenging the suggestion that having children might make midwives better midwives. This finding therefore supports the notion of empathy as a relational process (Siddiqui 1999), bound within the complex nature of the gendered identity of midwives as women.

MATERNAL IDENTITIES IN THE CONTEXT OF MIDWIFERY CARE

The construction of maternal identity, and definitions of motherhood and mothering were also an important aspect of this study. Significantly, the findings of the research highlight the relationship between motherhood and midwifery, specifically their emotionality. In Chapter 1 I considered the concept of matrescence (Thomas 2001; Walsh 2006) as a key aspect of the maternal nurturing qualities of care and as an attitude to care. Indeed, whilst some midwives were described as motherly, it was not always clear whether they were mothers; if they were, it was also unclear as to whether they were biological or social mothers. This finding suggests that care may not be exclusively gendered and challenges the gender expectations of midwives as female carers (Kent 2000). However, mothers within this research constructed the identity of the 'Good Midwife' based on the display of mothering qualities. Mothers considered that good midwives adopted a maternal identity, embracing emotional engagement in a way that was distinct from the approach of others. This finding reflects the significance of Swanson's (1991:163) theory of caring within midwifery, where care is defined as 'a nurturing way of relating to a valued other.'

Since this research emerged as a result of my analysis of whether it was important for a midwife to be a mother, the relationship between motherhood and midwifery is an interesting and complex finding. It is complex because the construction of the 'Good Midwife,' (Nicholls and Webb 2006), challenges the identity of the midwife as carer since mothers suggest that care is associated with the identity of a mother. Given that midwives and mothers within this research suggest that some female midwives did not display attributes pertinent to this identity, it does not wholly support the suggestion that matrescent care essentialises care as a female activity; rather it suggests that caring for women around birth demands certain skills of nurturing that some midwives possess whilst others do not. What this research has not been able to explore is whether male midwives also display these qualities; therefore in the absence of further data from male midwives and from mothers who have been cared for by male midwives, it is reasonable to support Walsh's (2006) preference for matrescence over maternalism in relation to care because of its gender neutrality. This finding also emphasises the relationship between matrescence and emotional intelligence where mothers' positive encounters with midwives considered as good midwives, described how these midwives were able to identify and address their emotional needs (Hunter 2004b).

The discussion of the conceptualisation of the identity of the 'Good Midwife' in Chapter 6 raises some concerns in relation to mothering and the maternal role of midwives as carers. It may be viewed as an example of 'Othering practice' (Canales 2000; Johnson et al., 2004), in which midwives who are non-mothers and young midwives may be considered as 'Others' are subject to prejudice, stereotyping and marginalisation. However, what is a significant issue here is the display of what the mothers perceive as maternal support, regardless of whether the midwives are social, biological or non-mothers. Furthermore, for some mothers, the sex of the midwife was not significant. Whilst some mothers thought that midwifery was a female profession and focused on the issues of intimacy around birth, others felt that male midwives were also valuable contributors within midwifery care and drew parallels with male doctors. Therefore, this thesis makes an original contribution in terms of illustrating how the analysis of gender identity shows the interconnectivity between midwifery, reproduction and motherhood, and emotion.

AUTO/BIOGRAPHY AND EMOTION WITHIN RESEARCH

This thesis contributes to the existing literature on the sociology of emotion as an example of how reflexivity, defined in terms of the relationship between the researcher and the respondent where the emphasis has been placed on power relations (Ramazanoğlu and Holland 2002), can be used in a positive and constructive way within auto/biographical research. I used reflexivity within this thesis as a means of furthering the quality of the research and a way to counter the possible criticism of self-indulgence. The personal form of reflexivity as described by Wilkinson (1988) is an example of this. By drawing on the relationship between being a situated researcher and the process of reflexivity, I show in this thesis how a researcher can manage emotion within an auto/biographical approach through a process of embracing the interrelated concepts of intersubjective, introsubjective and functional reflexivity as discussed in Chapter 2. What is significant to the use of reflexive auto/biography within the context of this research is the recognition that within intersubjectivity lays the concept of relational empathy. Finlay (2005:272) stated that 'empathy is not just about emotional knowing; it is a felt, embodied, intersubjective experience. It is also an experience that underpins researchers' ability to understand their participants.' This supports the nature of the relationship between the researcher and the respondent and is implicit within the researcher's reflexive approach to interviewing and data analysis.

The use of the hyphenated form of auto/biography reflects the bond between the distinctive contributions of both the researcher and respondent within the co-construction of knowledge. For midwifery research such as this, emphasising this mutual relationship has illustrated the feminist context of this thesis which privileges women's experiences within a feminist epistemological framework (Hughes 2002), and is central to the construction of accountable knowledge (Stanley 1990); knowledge which is validated by the social context within which it is produced. In this context, I suggest that this approach broadens the boundaries of current qualitative methods used to explore issues in midwifery, by placing a specific emphasis on the relationship between the researcher and the research in which relational empathy can be central to the researchers' ability to explore mutual meanings. My situatedness as a midwife, mother and woman was integral to the development of this research, and has illustrated how the relationship between gender identity and emotion was a key methodological issue in the exploration of women's embodied experiences of reproduction and childbirth. Furthermore, this

approach has been significant in demonstrating how my biography shaped the development and conduct of the research study. In this way, I consider the use of this approach to be one of the major strengths of this thesis.

By acknowledging the contribution of relational empathy within a reflexive approach, I also acknowledged that as a researcher, I could be as susceptible as the respondent to emotional issues within research (Letherby 2003), and in this context auto/biography could be a source of emotion work. As a situated researcher it was important for me to address how this was implicated within the research. In Chapter 3 I wrote about how much I enjoyed writing this thesis, but acknowledged that the process had also been emotionally difficult at times. Since work commitments had to be prioritised over interviewing, I thought I would never complete it. The motivation to seek some clarification and explanation for some of the questions I had developed many years ago, kept the passion burning and saw me through the process.

Throughout this research, I exposed my feelings on paper by detailing my biography and my own experiences. This was difficult to do at the start because I felt reluctant to engage with experiences that, at the time, I felt guilty about. Also I felt uneasy about placing the focus on myself, as I wanted to privilege the voices of the midwives and mothers. This process exposed my feelings of guilt and regret, which I now acknowledge. This process enabled me to 'look within' and consider my identity as a midwife, mother and woman.

Thus, as Morgan (1998: 655) notes:

[auto/biography is not] . . . simply a shorthand representation of autobiography and/or biography but also [a] recognition of the inter-dependence of the two enterprises. . . . In writing another's life we also write or rewrite our own lives; in writing about ourselves we also construct ourselves as some body different from the person who routinely and unproblematically inhabits and moves through social space and time.

And further as Lawler (2008: 13) suggests:

. . . the relationship between identity and autobiography is not that autobiography (the telling of a life) *reflects* a pre-given identity: rather, identities are *produced* through the autobiographical work in which all of us engage every day, even though few of us will formally write an 'autobiography'. The narratives we produce in this context are stories of how we come to be the way we are. But it is *through* the narratives themselves that we produce our identities in this way.

As it became clear that detailing my own experiences would enhance the application of an auto/biographical approach, I became more accustomed to being the situated researcher. I began to think about my experiences in more detail. I didn't know how much to write, and of course I needed to consider how my son would react if he read this thesis in the future. I didn't want him to think that I was exposing him unnecessarily for the sake of academic fulfilment (Letherby 2003). In Chapter 2 I detail a number of specific experiences which have been instrumental in the development of this research and also in forming my identity as a mother and my relationship with my son. My reflections on pregnancy and subsequent experiences made me realise how much I had missed the opportunity of having a second baby and doing those things which I didn't get quite right the first time. I never realised how reproduction, childbirth and becoming a mother would play such a large part in my life especially within the research context. Although my son was seven years old when I started this research, I still imagined that I would have a second child at some point. Now six years later, I have progressed from a childbearing woman to a pre-menopausal woman, in which my chances of having a second child have now diminished.

For researchers who plan their research around issues of personal relevance, it is important to recognise that the use of auto/biography is highly desirable, as researchers provide a specific perspective on the issues being explored (Letherby 2003). However, this approach could be challenging for the researcher, especially if issues have not been fully resolved. In this context, the discussion of the ethical issues of interviewing women in Chapter 3, illustrates the emotional vulnerability of the researcher (Johnson 2002). In addition, the exposure of personal details and emotion on paper can also be challenging as the researcher loses control of the information once it is written (Gruppetta 2004). Acknowledging the potential emotional upheaval within this kind of research was important for me, as recounting personal experiences could have resulted in the 'tin-opener effect' (Etherington 2004), where recalling certain events may have been as distressing for me as it could have been for the mother or midwife being interviewed. The process of interviewing mothers who described their expectations of a second or subsequent child made me feel quite sad at times and the feelings of loss I felt were quite reminiscent of those reported by infertile women (Letherby 2003). I should have made more of an effort to seek fertility advice; one thing that I still bitterly regret. At times, I consider that completing this thesis has been a way of justifying my decision not to seek

further advice as I feel that I have something to show for the last six years. Conversely, if I had had a second child this thesis may not have been completed. However, once the interviews had begun, I embraced the opportunity of actively exploring the issues that interested me and I often felt like a community midwife when I visited mothers at home to be welcomed by the offer of a cup of tea. This illustrated the significance of auto/biography as an approach in which my identities intersected at different times during the research process and illustrates the strength of the situated researcher.

One way in which I was able to counter the potential emotional upheaval was by analysing my own experiences at the beginning of this journey. This was important because when the researcher has no means by which to measure the impact of their own emotional status on the development or progression of the research, unexpected emotional disruption could impact on the researcher's relationship with the respondents. This could occur in relation to the rapport with the respondents where feelings of anger, resentment or denial may be present. This could effect the direction of questioning, and the responses received. As a result, the credibility of the research may suffer. In Chapter 2 I describe my experiences of pregnancy, childbirth and motherhood, which show that they were bound within an emotional context of being a woman and mother, and the professional context of being a midwife. In this context, I believe that I have engaged with auto/biography in an honest and transparent way.

In Chapter 3 I recount my experiences of interviewing a midwife who had similar experiences to me; I had examined my own experiences in some detail prior to interviewing and therefore this particular interview was more reassuring than emotionally upsetting for me. However, whilst she did not become emotionally upset during the interview, discussing our mutually shared experiences may have offered her some reassurances too.

Being an experienced professional may have supported my ability to manage my emotions during this process. Drawing on my skills and knowledge of working with midwives and mothers may have been useful to understand individual experiences. This is particularly evident in the range of embodied experiences described by midwives and mothers within the data chapters. However, whilst this may be true in this research, it does not preclude other researchers from exploring similar issues from an

auto/biographical perspective. Moreover, it may reflect the relationship between gender and emotion where women are expected to undertake more emotion management (Hochschild 1983), thus reflecting the gendering of emotional display (Dickson-Swift, Liamputtong and James 2008). As a means of addressing personal emotional issues as they arise, I suggest that the researcher must be able to reflect on their personal experiences sufficiently before embarking on the research and subscribe to a process of continually evaluating their responses as the research progresses.

Throughout the process of completing this research I have been aware of the possibility that my voice may be heard above those of the midwives and mothers whom I interviewed. As a result I made a conscious decision to structure this thesis to illustrate the balance and interaction between auto/biography and the voices of the midwives and mothers. The first three chapters clearly illustrate the way in which auto/biography influenced the development and conduct of this research and how this approach supported the use of a feminist theoretical framework (Harding 1986). Whilst I am present throughout the research, my decision to remain silent within the data chapters was an attempt to allow the voices of the midwives and the mothers to be prominent.

LIMITATIONS

Whilst research is rarely perfect, a potential weakness of this research could lie in the recruitment process employed and the resultant number of midwives within the study group. In Chapter 3 I described the difficulties experienced in recruiting midwives into the study. Although the method employed utilised posters and flyers, I did want to avoid the potential criticism of institutional pressure and on further reflection I feel this approach was justified. Whilst it took 18 months to recruit fourteen midwives, if I was to do this study again I would employ a more direct approach to recruitment utilising team and unit meetings and developing a closer relationship with the Trust prior to and during the recruitment. Following the completion of the first interviews for the midwives, I took time to reflect on the experience and my position as a researcher which resulted in a more direct approach. In fact when I started to recruit mothers for the research, between February 2007 and April 2007, 15 mothers agreed to take part of which 13 mothers were finally interviewed.

A further weakness may relate to the composition of the study groups. Although in the study group of midwives, twelve were Caucasian and two were non-Caucasian, in the study group of mothers, all were Caucasian. Due to the lack of interpretation services, mothers who were unable to speak English were excluded from the research. Exploring the experiences of mothers from different ethnic and cultural backgrounds may have revealed different cultural expectations and experiences of working with midwives. Similarly, their accounts may have contributed to a different construction of the midwife's identity. Interestingly, during the period of the recruitment I came across few, if any, mothers who were non-Caucasian that could speak English. Furthermore, to determine the general social class position of the mothers within the research, the National Statistics Socio-economic Classification (NS-SEC) (ONS 2000) was applied on the basis of their current or previous employment. Since the majority of mothers were classified as group 3 Associate Professional and Technical Occupations, one might suspect that their experiences of childbirth on this basis may highlight a better understanding of choice and involvement in their care, and therefore, this may have equipped them to be more critical of the care they received.

Another weakness may relate to the fact that I did not interview male midwives within the research. To fulfil the aim of exploring the gendered nature of midwifery as an example of 'women's work', I decided to focus on the relationship between women. Since no male midwives were employed in the Trust, a decision to include male midwives from another part of the region may have been viewed as tokenism and for that reason I decided not to pursue this aspect. Alternatively, I decided to broaden my focus within the interviews with mothers to include discussion of the idea of male midwives.

POLICY AND PRACTICE RECOMMENDATIONS

The accounts of both midwives and mothers discussed within this research reflect how emotion is central to the experiences of pregnancy, childbirth and motherhood and to the care received from midwives around the time of birth. A key aspect that underpins the policy and practice recommendations discussed here is the impact that the location and provision of services have on the experiences of mothers, especially in terms of whether their needs are met and the way in which midwives work. This leads me to propose the following:

a. Key documents that govern current maternity policy provision (DH 2004; DH 2007 and DH 2008), place an emphasis on quality care focused to meet women's needs. In the light of the findings from this research that some mothers feel unsupported in hospital where inadequate care is experienced, the suitability of the hospital as the location of midwifery care should be re-examined; the planning and commissioning of maternity services must take into consideration the emphasis placed on expanding community based provision as articulated in the National Service Framework for Children, Young People and Maternity Services (NSF) (DH 2004).

b. Whilst community based services may enable more mothers to be cared for within their own homes, the findings of this research highlight the need to review the delivery of hospital based postnatal care as a priority, in terms of the provision of immediate postnatal care and support within a woman-centred philosophy. Since there is an emphasis on kindness, respect and dignity within the care of mothers and their families in the NICE clinical guidance for Postnatal care (NICE 2006), the organisation and delivery of services to meet mothers initial needs must be considered a priority within the review of these guidelines due in 2012.

c. The recent publication of the report 'Delivering high quality midwifery care: the priorities, opportunities and challenges for midwives' (DH 2009), outlines steps to develop and enhance the role of midwives and the future development of midwifery to provide high quality personalised care. Since mothers' perception of the identity of the midwife as a carer is clearly illustrated in this research, and shows how a good trusting relationship between the midwife and the mother can facilitate a positive experience for the mother, more emphasis should be placed on the negative effect of midwives' poor attitude and behaviour. Whilst supervision is highlighted as a way to support midwives, supervision must also be emphasised as a means by which midwives behaviour can be identified, monitored and managed.

d. The findings of this research recommend that whilst NHS employers have a duty under the Management of Health and Safety at work (MHSW) Regulations 1999 to undertake an assessment of risks to pregnant and new mothers, the Supervisor of Midwives (SOM) may be better placed to conduct a debriefing discussion with midwives before they return to work following maternity leave. Furthermore, whilst NHS employers have a duty to make adjustments to the working environment which

may include changes in shift patterns and moving pregnant midwives from high-risk areas of work to another, the Supervisor of Midwives is ideally placed to act as an advocate for the midwife in a professional capacity, to ensure that the midwife is fit for purpose and fit for practise. As a result, the Preparation and practice of supervisors of midwives (NMC 2006) and Rule 12 - The supervision of midwives (NMC 2004) will need to be reviewed in this context. To enable transparency, 'The Modern Supervision in Action: a practical guide for midwives' (NMC 2009) would also need to be reviewed to address this. Student midwives returning to their programmes of study and to the clinical midwifery environment following childbirth, will also benefit from this practice recommendation and further counselling support services should be made available to all staff on an individual and voluntary basis.

RECOMMENDATIONS FOR FUTURE RESEARCH

Although this research has found that emotion is central to the identity of the midwife and the relationship between midwifery and motherhood, this research also raises further questions of interest that underpin the recommendations for further research stated here. These are considered under three specific themes: Methodology, Midwives and Care.

METHODOLOGY

This thesis has illustrated the relevance of emotion to auto/biography in a specific context. Further work is required to develop the use of auto/biography as a research approach within midwifery, in order to understand the emotional challenges encountered by midwifery researchers. This will enhance the understanding of the relationship between the researcher and the respondent but also between the researcher and the research topic.

In addition, further work is required to explore the role of emotion as a central principle of qualitative enquiry within midwifery. Since researchers have few opportunities to talk about the emotions they experience when conducting research, an exploration of the emotionality of research will further advance our understanding of the consequences of emotion work for researchers.

MIDWIVES

Identity Issues

The identity of midwives as an oppressed group requires further examination in the context of midwifery culture. This should be explored in terms of the relationship between midwives and mothers, and the relationship between midwives in the wider context of the cultural and professional significances within midwifery.

Exploring identity in relation to midwives and midwifery from an interprofessional perspective may be useful to examine the social and professional construction of midwifery and its association with motherhood within the wider context of healthcare professions.

Embodied experiences

Issues around the physical and emotional demands of working as a midwife during pregnancy were highlighted in this research, but merit further exploration in view of the possible impact of experiences on the midwife. Therefore, exploring the embodied experiences of a more specific study group of pregnant midwives would be beneficial in the context of examining the effect of pregnancy on midwives experiences, and relationships with women and midwives. In addition, exploring the issue of safety - both emotional and physical - would benefit policy development in relation to the provision of support of pregnant midwives. Furthermore, we also have limited knowledge of the experiences of midwives returning to work following childbirth and following miscarriage, stillbirth and neonatal death.

Whilst the majority of mothers in my research would choose a female midwife rather than a male midwife, an exploration of the experiences of male midwives would be useful in the context of the embodied experiences of fatherhood and in the context of the debates around gender identity within contemporary midwifery practice. An exploration of the experiences of student midwives (both female and male) who return to the midwifery programme following childbirth also merits further exploration in relation to their experiences of birth, motherhood and fatherhood.

MIDWIFERY CARE

The relationship between mothering and midwifery was not explored in relation to non-Caucasian mothers within this research. Therefore this relationship requires examination from the perspective of mothers from different ethnic groups. This research may further our understanding of the identity of the midwife and the role that emotion plays within it, from the specificities of diverse, multiethnic experiences of midwifery care and support within the UK. This would also act to explore points of connection, incompatibilities and areas of confusion.

Whilst an in-depth examination of midwifery care was not the focus of this research, the association between caring and mothering has been established in relation to the identity of the 'Good Midwife'. Therefore, an examination of the understanding of midwifery care and an in-depth exploration of the concept of maternal support within midwifery would be of value.

The relational aspects of emotion work merits further exploration in terms of the points of similarity and difference between midwives and mothers as women in relation to the concept of oppression.

FINAL THOUGHTS

This research has examined the issue of gender identity in relation to midwives, midwifery and motherhood and has found that the relationship between emotion and the midwife's identity makes a significant contribution to our knowledge and understanding of how gender works in midwifery. Exploring gender identity in midwifery work reveals the significance of emotion within the relationship between midwives and mothers, and how this can create different sources of emotion work for midwives and mothers.

This research presents an insight into the relational aspects of emotion work within reproduction and childbirth, and reveals that emotion work is not limited to midwives. This relates to the nature of midwifery care and extends the current literature by focusing on the relationship between the provision of woman-centred care and what that means to the identity of the midwife as a carer, especially within the hospital environment.

This thesis illustrates how midwives use their embodied knowledge of pregnancy and birth to form and reform boundaries between their professional identity and their embodied experiences as mothers, as a means of controlling emotion. Emotion is key to mediating the relationship between midwives' experiences and their practice and this is especially significant in relation to their identity. The findings of this research make an original contribution to the understanding of the relationship between emotion, midwives embodied experiences of reproduction, childbirth and motherhood, and the issue of professional identity.

The analysis of gender identity shows the interconnectivity between midwifery, reproduction and motherhood, and emotion. Midwifery and motherhood in this context are gendered ways of being in the world and emotion work is a major part of that, conceptualised within the identity of the 'Good Midwife'. This identity construction suggested that caring for women around birth was associated with the identity of a mother, where care was based on the skills of nurturing and the relationship between matresence and emotional intelligence.

Whilst some limitations have been identified and discussed within this chapter, this thesis illustrates how reflexivity can be used in a positive and constructive way within auto/biography as a means of managing emotion work, where the position and contribution of the situated researcher is central within the research. The use of auto/biography within this research highlights the relevance of emotion within auto/biography and the value of this to the development of midwifery research.

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APPENDIX 1: LETTER OF INFORMATION AND INVITATION FOR MIDWIVES

LETTER OF INFORMATION and INVITATION FOR MIDWIVES

MIDWIVES AND MOTHERS: REPRODUCTIVE IDENTITIES AND EXPERIENCES

Dear Colleague,

I am writing to seek your assistance with my ongoing research study.

What is the study about?

Recent papers (Rowan 2003; Bewley 2000a; Bewley 2000b) have highlighted issues in practice in relation to midwives who have experienced infertility. My aim is to broaden this discussion by exploring the 'real life' experiences of midwives in relation to their own reproductive experiences/expectations. Although midwives are often asked whether they have children, this issue has not been explored in the literature. The significance of this question to mothers and also to midwives in terms of how they view their own reproductive experiences in relation to clinical practice and relationships with mothers in their care will be the main focus of this study.

Through a process of exploration and interpretation, I aim to make a significant contribution to the theoretical and sociological understanding of identity in relation to reproduction, motherhood and midwifery work, in which an understanding of the 'meaning of motherhood' from the perspective of both midwives and mothers, will be examined.

In order to achieve this broad aim, I am interested to talk to any midwives who wish to discuss their reproductive experiences. These experiences can be defined very broadly to include complicated and uncomplicated pregnancies and deliveries, in addition to experiences of miscarriages, stillbirth or neonatal death. I would also like to speak with midwives who have decided not to have children, those who wish at some stage in the future to have children and midwives who have experienced infertility.

How will the research be carried out?

Participation in this study is voluntary. Individual tape-recorded in-depth interviews will be conducted with 20 midwives and 20 mothers within the postnatal period. Midwives will be interviewed on one occasion during the course of this research study, while mothers will be interviewed once during the postnatal period

Anonymity of interview data will be encouraged by the use of pseudonyms given to the midwives and women. No reference to the true identity of the individual midwife or mother is made during the tape recording process or during the transcription process, therefore maintaining confidentiality. This also applies to the use of excerpts from written transcripts, which may be quoted in future papers, journal articles and books.

Who is conducting this study?

I am a senior lecturer in midwifery at The University of Northampton, and this study forms the basis of my part-time PhD studies. All the interviews will be conducted by myself, following the completion of a consent form. The location of the interviews will be chosen by you.

Further questions about the study

If you would like to participate in this study, please complete the form attached so that I can contact you to discuss the study and arrange the interview, and return it to me in the stamped addressed envelope enclosed. By returning this form, you are under no obligation to participate and you may change your mind at anytime.

A copy of the consent form is however included for your information only, and is not required to be returned by post.

Alternatively if you would like to discuss your participation in this study further, please contact me at the address below in writing or by telephone, or contact me by email. All enquires will be considered in strict confidence.

In anticipation, I thank you for helping me with this research study.

Yours sincerely,

Sarah Church
Senior Lecturer /PhD student

School of Health
The University of Northampton.
01604 735500 x2275 (Direct line 01604 89 2275)
email: sarah.church@northampton.ac.uk

REFERENCES

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If during the course of your participation, you wish to speak to someone outside the study about any issues, which may be causing you stress or anxiety, please contact any of the services below:

Caroline Beaumont BAC UKRC (Accredited Counsellor)
Church House High Street
Hardingstone
NN4 6BZ 01604 765513

Northampton Pastoral Counselling Service
01604 78433

APPENDIX 2: LETTER OF INFORMATION AND INVITATION FOR MOTHERS

LETTER OF INFORMATION and INVITATION FOR MOTHERS

MIDWIVES AND MOTHERS: REPRODUCTIVE IDENTITIES AND EXPERIENCES

Congratulations on the birth of your baby!

I am writing to ask for your assistance with my ongoing research study.

What is the study about?

In many cultures, the midwives' own experience of childbirth appears to be very important. It is reported that mothers often ask midwives if they themselves have children. Recent research has examined the feelings and experiences of midwives with infertility working with mothers and babies. However, my interest is to broaden this discussion by exploring the day-to-day experiences of midwives in relation to their own reproductive experiences/expectations.

My aim in conducting this piece of research is to analyse this issue in more detail, in order to understand how midwives view themselves, their professional relationships with mothers, and their own reproductive experiences/expectations. Since the relationship between the midwife and the mother is so special in midwifery care, it is also essential to explore these issues from the mother's point of view, and therefore your contribution is important.

In order to achieve this broad aim, I am interested to talk to you during the postnatal period, about your own reproductive experiences and your relationships with midwives. I am interested to hear from mothers who have experienced complicated and uncomplicated pregnancies and deliveries, all resulting in a normal healthy baby.

How will the research be carried out?

Participation in this study is voluntary and confidential. Individual tape recorded in-depth interviews will be undertaken with 20 mothers on one occasion, within the first six weeks following delivery. All the interviews will be conducted by myself, following the completion of a consent form. The date, time and location of the interviews will be chosen by you.

All interview data will be anonymous and this will be ensured by the use of pseudonyms. No reference to your true identity is made during the tape recording process or during the transcription process, therefore maintaining confidentiality. This also applies to the use of excerpts from written transcripts, which may be quoted in future papers, journals articles and books

Who is conducting this study?

I am a senior lecturer in midwifery at The University of Northampton, and this study forms the basis of my part-time PhD studies. All the interviews will be conducted by myself, following the completion of a consent form.

Further questions about the study

If you would like to participate in this study, please complete the form attached so that I can contact you to discuss the study further, and return it to me in the stamped addressed envelope

enclosed. By returning this form, you are under no obligation to participate. A copy of the consent form is included for your information, which will be completed prior to the interviews.

Alternatively you can contact me at the address below in writing or by telephone, or contact me by email. All enquires will be considered in strict confidence.

In anticipation, I thank you for helping me with this research study.

Yours sincerely,

Sarah Church
Senior Lecturer /PhD student

School of Health
The University of Northampton

01604 735500 x2275 (Direct line 01604 892275)

email: sarah.church@northampton.ac.uk

If during the course of your participation, you wish to speak to someone outside the study about any issues, which may be causing you stress or anxiety, please contact any of the services below:

Caroline Beaumont BAC UKRC (Accredited Counsellor)
Church House High Street
Hardingstone
NN4 6BZ 01604 765513

Northampton Pastoral Counselling Service
01604 784330

MIDWIVES AND MOTHERS: REPRODUCTIVE IDENTITIES AND EXPERIENCES

CONSENT FORM

Name:.....

Address:.....

.....

Post Code: Telephone Number:

Please tick

I in signing this consent form, I agree to participate in the research study being conducted by SARAH CHURCH

I have received written and verbal explanations of this research and I have had the opportunity to ask questions and have had those questions answered to my satisfaction.

I understand that the research being conducted aims to provide an in-depth exploration of the 'real life' experiences of midwives, in relation to their own reproductive experiences/expectations and their relationship with mothers in their care. I understand that excerpts from my written transcripts and tape-recorded verbal communications with the researcher will be studied and may be quoted in a doctoral thesis and in future papers, journal articles and books that will be written by the researcher.

I grant authorization for the use of the above information with the full understanding that my anonymity and confidentiality will be preserved at all times.

I understand that my full name or other identifying information will never be disclosed or referenced in any way in any written or verbal context.

I understand that transcripts, both paper and electronic versions, will be kept securely at The University of Northampton and that any audio tapes of my conversations with the researcher will be erased following analysis and the successful completion and publication of any material from the thesis.

I understand that my participation is entirely voluntary and that I may withdraw my permission to participate in this study without explanation at any time, and without affecting my present or future care.

Respondent Signature:..... Date:.....

Researcher Signature:..... Date:.....

MIDWIVES AND MOTHERS: REPRODUCTIVE IDENTITIES AND EXPERIENCES

PLEASE TICK

I am interested in participating in the research study being conducted by SARAH CHURCH and I would like to discuss it further

I understand that by returning this form, I am under no obligation to participate

Name:.....

Address:.....

.....

Post Code: Telephone Number:

APPENDIX 5: BIOGRAPHICAL DETAILS OF THE STUDY GROUP OF MIDWIVES

Respondent [PSEUDONYM]	Age	Marital Status	Reproductive Status	Professional Status
Alice	44	Divorced	Four children [One of which died - Sudden Infant Death Syndrome].	Pre-registration midwife
Anita	50	2 nd Marriage	Long term infertility One child	Post-registration midwife
Ann	43	2 nd Marriage	Two children	Post-registration midwife
Chris	46	Married	Three children	Post-registration midwife
Grace	55	Married	Two children	Post-registration midwife
Jackie	40's	Married	Three children One miscarriage	Post-registration midwife
Julie	30's	Married	Two children	Pre-registration midwife
Kirstie	33	Married	Three children	Post-registration midwife
Lucy	33	Married	Two children	Post-registration midwife
Rebecca	25	Married	No children	Pre-registration midwife
Susan	30	Cohabiting	Two children	Pre-registration midwife
TRACEY	31	Married	No children	Pre-registration midwife
Trish	40's	Married	Three children	Post-registration midwife
Vicky	20's	Single	No children	Pre-registration midwife

BIOGRAPHIES OF MIDWIVES

ALICE, is a 44 year-old-woman. She has been a midwife for 4 years and works full time in a maternity unit. Although she has been twice married, she is currently divorced and has spent much of her time as a single mother. She is a grandmother and also a foster mother to many teenagers. She has had four children one of which died of Sudden Infant Death Syndrome (SIDS). Other traumatic and eventful experiences include postnatal depression, a cord prolapse an Obstetric emergency, which necessitates an emergency caesarean section. She met her second husband who was much younger than her. He wanted to start a family but she was initially reluctant. After a few years she discovered that she had fertility difficulties. She conceived with the help of fertility drugs. Her third child was born after an easy pregnancy and Alice described the birth as a 'nice birth'. Three months after the birth Alice became unwell with Gallstones. Unfortunately no treatment could be given because she had fallen pregnant in the meantime. Three months after the birth of her fourth child she was admitted to hospital for removal of the Gall Bladder. During her hospitalisation, Alice's mother looked after the children for most of the time since her husband worked away. One month after she was discharged home her husband left her. Alice explains that she was left with three children and recovering from 2 major operations. She explains how traumatic it was to be present at her grandchild's birth when difficulties were experienced.

ANITA, is a 50-year-old woman mother of one child. Anita is an experienced nurse and midwife who has worked as a midwife for over 20 years. She experienced infertility for many years, which contributed to the breakdown of her first marriage. After meeting her second husband, she conceived unexpectedly at the age of 45. She experienced a spontaneous vaginal birth. She breastfed her baby successfully.

ANN, is a 43-year-old woman. She is a trained nurse and midwife and is currently working as a midwifery specialist. She has worked as a midwife for over twenty years. She has two teenage children from her first marriage. Both her children were born by Caesarean Section. Having remarried she is planning another pregnancy.

CHRIS, is a 46-year-old married woman and mother of two children. She is a trained nurse and midwife and has been a midwife for the last 12 years. She works full time in a busy maternity unit. She experienced three spontaneous vaginal births. Breastfeeding was difficult with her first child.

GRACE, is a 55-year-old married woman and mother of two grown up children. Grace is a trained nurse and midwife and has been a midwife for the last 30 years. During her first pregnancy she experienced high blood pressure and was induced. She experienced two spontaneous vaginal births. Her second baby was birthed after 20 minutes in labour. She breastfed both her children.

JACKIE, is a midwife in her mid forties who is married with three children. She has recently returned to midwifery after a career in nursing and research. She works part-time in a busy maternity unit. Jackie experienced three spontaneous vaginal births. She experienced perineal problems following the first child. She also experienced a miscarriage. She breastfed all her children successfully.

JULIE, is a married woman in her early thirties and works part-time in a busy maternity unit. Bother her children were spontaneous vaginal births; a waterbirth with her first baby and a home birth with her second. She breastfed both her children successfully.

KIRSTIE, is a 33-year old married woman, and a mother of three children under 10 years. After completing her nurse training, she decided to become a midwife. She's been a midwife now for the last 8 years and works part-time in a busy maternity hospital. Kirstie experienced three spontaneous vaginal births. Her second child was born at home and her third child was born prematurely at 35 weeks. Although she breastfeed all her children she experienced a number of problems.

LUCY, is a 33-year-old woman mother of two children. She is a qualified nurse and midwife and has practiced as a midwife for the last 5 years She works fulltime in a busy maternity unit. She has two children under 5. Lucy experienced two spontaneous vaginal births; the second baby was born at home. Lucy breastfeed both children successfully.

REBECCA, is a 25-year-old woman who is a newly qualified midwife. She is planning a pregnancy and looks forward to being a mother. Rebecca is generally anxious about the possibility of not being able to have a baby.

SUSAN, is a 30-year-old woman. She has been qualified as a midwife for 2 years and works part-time in the maternity unit. She has two children and is planning to have another baby with her new partner. Susan bottle fed both her babies but is determined to breastfeed the next baby. Her first baby was born when she was 15 years old. Whilst her first pregnancy was uneventful, her second pregnancy was marred by the memory of a painful labour and the experience as an Obstetric Emergency, which she confirmed to be a Shoulder Dystocia.

TRACEY, is a 31-year-old married woman. Tracey qualified as a midwife 3 years ago and works both in the community and in the maternity unit. She is married and is planning a pregnancy.

TRISH, is in her mid forties. She is married with three children. Although she is a trained nurse and midwife, she is currently registered as a midwife and works part-time at a busy maternity unit. She has had three children preceded by one miscarriage. Two of her children were spontaneous vaginal births and one of her children was born with the aid of forceps. She breastfed her children successfully.

VICKY, is a midwife in her early twenties who has been qualified for nearly one year. She is single and lives with female friends. She has never been pregnant and wants to have children when she meets the right man

APPENDIX 6: BIOGRAPHICAL DETAILS OF THE STUDY GROUP OF MOTHERS

Respondent [PSEUDONYM]	AGE	Marital Status	Reproductive Status	Professional Status
ANGELA	30	Married	Second baby Both spontaneous vaginal births. Breastfeeding	Banking executive NS-SEC 1
BELINDA	31	Married	Second baby Both born by Caesarean section. Breastfeeding	Counsellor NS-SEC 3
CARRIE	30	Married	One child Ventouse delivery Breastfeeding	Journalist NS-SEC 3
DAWN	27	Married	First baby Spontaneous vaginal birth Breastfeeding	Marketing Manger NS-SEC 1
EMILY	36	Married	First baby Caesarean section Breastfeeding	Legal Executive NS-SEC 3
ELOISE	41	Married	Second baby. Both born by Caesarean section Breastfeeding	Accountant NS-SEC 2
FIONA	24	Married	Twins first pregnancy Both born by Caesarean section Bottle feeding	Nurse NS-SEC 3
GAYNOR	19	Single stable relationship	First baby Spontaneous delivery Breastfeeding	Hairdresser NS-SEC 6
JESSICA	33	Married	Second baby Both born by Caesarean section. Breastfeeding	Teacher NS-SEC 2
LAURA	33	Married	Second baby. One previous miscarriage. Both born by Caesarean section. Breastfeeding	Library Assistant NS-SEC 4
MARY	30's	Married	First Baby Spontaneous vaginal birth Bottle feeding	Communication officer NS-SEC 3
MEGAN	31	Single stable relationship	Second baby Ventouse delivery Previous Spontaneous vaginal birth (13 years ago) and two previous miscarriages. Bottle feeding	Housewife and mother N/S
TANIA	30's	Co-habiting	Second baby Both Spontaneous vaginal births Bottle feeding	Shop assistant NS-SEC 7

BIOGRAPHIES OF MOTHERS

ANGELA, a thirty-year-old mother of two children, worked for many years as a banking executive and has been married for a few years to her husband Mike. Her son is 2 years

old and her daughter is 5 weeks old. Her first birth was traumatic resulting in perineal stitches and had a catheter for a short time after the birth. She is breastfeeding.

BELINDA, a thirty-one year old mother of two children, worked as a counsellor for the health service and has been married to husband Nick for a few years. In her first pregnancy two and a half years ago, she experienced high blood pressure, which resulted in the induction of labour and emergency caesarean section at 37 weeks. She experienced a wound infection post delivery. Both her son Jake and daughter Helen, 5 weeks old, were breastfed. Her father died during her second pregnancy when she was 25 weeks.

CARRIE, a thirty-year-old freelance journalist, gave birth to her first baby six weeks ago following a ventouse delivery. She has been married to Rob for a few years. She is breastfeeding her son Thomas who has been receiving cranio-sacral osteopathy following the delivery.

DAWN, a twenty seven year old and is married to husband Tim. She worked for a large multinational company as a marketing manager. Her first baby Michael was born by spontaneous vaginal delivery 5 weeks ago and is breastfeeding well.

ELOISE, a forty one year old accountant has been married for a few years. Her daughter, Tabitha, is three years old and was born by an emergency caesarean section. Her son Ben was born by elective caesarean section and is now 4 weeks old and breastfeeding well. She intends to return to work in a year's time.

EMILY, a thirty six year old legal executive, gave birth to her first baby, Rebecca, by elective caesarean section for breech presentation. She has been married for a few years. She intends to return to work although doesn't really want to.

FIONA, a twenty-year-old nurse gave birth to twin girls (Molly and Lilly) by emergency caesarean section at 34 weeks. Now at 6 weeks old the twins have been discharged home and both are well and being bottle-fed. She has been married for a few years.

GAYNOR, a nineteen-year-old hairdresser, lives at home but is in a stable relationship. She was already 18 weeks when she found out she was pregnant and was undecided as to whether to have a termination or not. When she decided to continue with the pregnancy, she was 24 weeks pregnant when she booked with the midwife. Following a spontaneous vaginal delivery of a baby girl, Lily, she returned home breastfeeding.

JESSICA, a thirty three year old teacher gave birth to her second son, Samuel, by elective caesarean section. Following the birth of her first son, David, by emergency caesarean section following a long labour, she opted for an elective caesarean section for her second pregnancy. She is married to Ricky for many years.

LAURA, a thirty three year old library assistant, gave birth to her second baby, William, following a labour for 18 hours, which resulted in an attempted forceps and an emergency caesarean section. Her first child Hannah who is nearly 4 years old was born by an emergency caesarean section for breech presentation.

MARY, a communication officer, is in her thirties, had planned a home birth but had a spontaneous vaginal delivery in hospital of a baby daughter Polly, following an induction of labour eleven days following the due date. Mary has been married for a few years.

MEGAN is a thirty one year old woman in a stable relationship. She gave birth to her second child after a gap of thirteen years. She had her first baby Josh at the age of 17 years. Following his birth she experienced postnatal depression, which appeared to last for a few years. She also experienced two miscarriages, before conceiving her second child a daughter Carly who is 5 weeks old and bottle-feeding.

TANIA, a mother of two children Andrew aged 3½ and her daughter Fleur aged 4 weeks, lives with her partner. She worked as a shop assistant. Both her children were born spontaneously and both were bottle-fed. She experienced an infection following the birth of her son, which lasted for a number of weeks.