‘Powers, passages and passengers’: the construction and performance of student midwives’ professional identities

Constance Mcluckie

2313443

Thesis submitted for the degree of Doctor of Philosophy

University of Stirling, Faculty of Social Science

February 2021

Declaration

This thesis has been prepared in accordance with the University of Stirling Research Degree regulations. I declare that this thesis is my own work and represents the results of my own research and writing. Where relevant I have acknowledged the nature and extent of work carried out in collaboration with others included in the thesis.

Abstract

This thesis details my study of the discourses within which student midwives construct and perform their professional identities. The title employs a metaphor commonly used in midwifery and obstetric texts to articulate the powers, passages and passengers involved in labour and birth. I use it allegorically as a metaphor for the 'powers' of policy, the 'passages' of professional learning, and the students as 'passengers' therein.

The key words for consideration are construction, performance, identities and discourses. 'Construction' uses 'small stories and positioning analysis' theorised by Bamberg and Georgakopoulou (2008). Analysis orientates through three levels, from locally constructed contexts of self to wider socio-cultural perspectives. 'Performance' uses visual analysis and 'micro-dramas', which I developed as part of this thesis; enabling me to investigate how identity is produced in conjunction with the material objects that constitute practice.

'Identities' uses sociolinguistic perspectives proposed by Bucholtz and Hall (2005, p. 585), defined as 'the social positioning of the self and other'. Finally, 'discourses' are explored using Fairclough's discourse analysis (1992). Here I examine how policy shapes midwives' identities and creates preferred 'subject positions' for midwives to adopt. Each element of analysis combines to surface the ways in which these positions are taken up or resisted by the student midwives (n=16), in relation to policy and their own small stories and micro-dramas.

I conclude with three important contributions to the literature. The first relates to discursive constructions of ‘midwives’ and the significance that this has for the development of midwifery education and practice. Second, is the extension of knowledge relative to midwives’ emergent professional identities. This comes during a time of unprecedented interest in the professional status of NHS workers and is therefore important to both current and future understandings of who midwives are and what they do. Finally, I propose a new methodology for exploring identity constructions and performances relative to small stories using gesture and material artefacts.

Acknowledgements

I would like to thank my academic supervisors Professor Cate Watson and Professor Walter Humes. I am indebted to their presence, wisdom, guidance and good humour throughout. Perhaps forbearance should be in there too.

The student midwives who participated in the study have long since graduated and I hope they are safe, well and supported in these extraordinary times. I am extremely grateful to them for agreeing to be interviewed and sharing their experiences; it feels like they have been alongside me all the while.

Love and thanks to my husband Garry, who didn't take the opportunity these last years to learn to cook, but has become a fastidious ironer; my daughter Katie, whom I promise to take shopping when we are allowed out; my son Alistair, who seems to know exactly the right moment to administer a hug; and Hector the dog, who has slept well throughout.

Thanks to my mum, Laura, for unconditional love and being really good at feigning interest; and my big sister Mel, who created the conditions for success by being quite bossy and impossible to let down.

Finally, the Smiths. Thanks to my dad, Ian, who I have looked up to all my life – mostly because he is a pilot; my uncle Alistair who told me I would never reach my full potential or understand the politics of life without university – I am still there and trying; and Gran and Grandad who I miss every day.

'As an effect of discourse, the figure of the midwife in Tristram Shandy represents, among other things, a nexus of crucial positions in the early-modern debates about obstetric authority in general and licensing in particular, debates which clearly indicate a strong and persistent male fear of what these women might get up to if left to manage childbirth on their own.'

(Landry and MacLean, 1990)

Table of Contents

List of Tables

List of Frames

List of Figures

Preface – Who am I in all this?

In 1969 when my mother was nineteen, she became pregnant and was duly despatched one hundred and twenty miles away from home to live with her sister until her baby was born. When she gave birth she was in a strange place, frightened and with no-one to comfort her or hold her hand. Her recollections of a cold and stark environment with midwives to match, and then the joy that came with my big sister were not what drew me to midwifery. That would be a nice story, but a bit of a cliché.

Instead, having dropped out of University at eighteen I got a job at the local 'Job Centre' and quickly realised that the civil service was not for me either. An advert for a 'new' midwifery degree in the local newspaper caught my eye one grey lunchbreak, and that was that.

As a practising midwife I tried to care for women and their families in the way that I would have liked my mother to have been cared for; and although serendipity was more to play than anything in my embarking on this career, the central premise of my practice both as a midwife and as an academic has been, and still is, the significance of caring and compassionate relationships and their power to sustain.

Chapter 1 - Introduction

This thesis is concerned with the ways in which student midwives construct and perform their professional identities and how these are implicated in professional learning and practice. It aims to explore the identities of midwives that are imagined and represented in professional and educational policy, and the identities of those who become midwives; identities that are constructed and performed, emerging in and through the practices of professional learning. The purpose of which is to provide a new perspective from which to approach improvements to policy, education and practice.

In this chapter I discuss the motivation and inspiration for the study. The gap in knowledge that the study aims to address is proposed and the research questions developed to do this presented. I then explain the background, context and rationale for the philosophical perspectives that underpin the thesis. The chapter ends by setting out the structure of the thesis.

Motivation and inspiration for the study

I like Edward Said's (1978) framing of beginnings; that beginnings aren't really beginnings they are already a project underway. When I started this project six years ago, my initial research proposal talked of midwifery education, the midwifery curriculum and opportunities for innovation therein (whatever that meant - possibly 'flipping the classroom'), all with the broader objective of improving the experiences of midwifery students. The antecedent of this point was a question posed at an end of programme evaluation by a final year student who was unhappy with the mark she had been awarded by her mentor

for her clinical practice. She asked ‘why do you not change things’? The question was a good question, but one that was given a poor answer. I blamed the University regulations (Edinburgh Napier University, 2015) and the statutory governance of the Nursing and Midwifery Council [NMC] (NMC, 2009); however, her position did cause me to question many of the practices inherent in providing a programme of professional learning. What I know now that I didn’t know then, is that innovating curricula and flipping a classroom does not offer sufficient possibility to ‘change things’ and that there are far more influences in the mix than the two sets of regulations described above.

The title of my thesis ‘Powers, Passages and Passengers’: the construction and performance of student midwives’ professional identities uses a metaphor which has been commonly used in midwifery and obstetric texts (Tydeman and Rice, 2016). ‘Powers, passages and passengers’ refers to the mechanical factors at play in a woman’s labour. The ‘powers’ being the forces expelling the fetus; ‘passages’ refers to the birth canal, the hard and soft structures of the pelvis which move and stretch to accommodate the passengers; and the ‘passengers’ are the fetuses, whose skulls mould and are shaped in response to the pressures that the powers and the passages exert on them. A shape, which will hopefully enable them to be born.

I employ it as a metaphor for what happens to those who enter onto programmes of midwifery education. Where, as student midwives, they are squashed into unfamiliar terrains, subject to and participant in (in)flexible practices, required to learn the boundaries (or not) of relationships, spaces and places; finally emerging with a new ‘shape’ which should enable them to ‘fit’ the

requirements of professional practice. I have my own experiences of being moulded and squashed into shape (not always willingly) by the regulatory requirements of the NMC, the organisational needs of the National Health Service [NHS], and the competing demands of Approved Education Institutions [AEI]. In this thesis, therefore, the metaphor is employed figuratively to represent the powers of policy, the passages of educational practices and the student midwives as passengers therein. It does this as a means to explore the ways in which student midwives construct and perform their professional identities.

Arriving at the point of departure - preliminary perspectives

The first book I read as a doctoral student was Michel Foucault's 'Discipline and Punish' (1979) and I don't suppose my being drawn to this was accidental. As I read about 'discourse', 'disciplinary power' and 'docile bodies', the metaphor of 'powers, passages and passengers' I rote learned as a student midwife became increasingly prevalent in my thoughts and was influential in the direction my ontological perspectives were to take. Foucault (1979) asks that we consider that the subject emerges from the discourse not in control of how they are shaped, that somehow out of the words the subject is revealed and resolved. I therefore sought to find a means by which to explore the ways in which policy 'shapes' midwives and how student midwives might 'shape' themselves.

Concomitant with other professions, midwifery is subject to a regulatory framework which sets the standard for education and practice. These are 'The Standards for Pre-registration midwifery education [SPRME] (NMC, 2009) and set the absolute requirements for what midwives should 'be'. The experience of

becoming a midwife, however, is entangled with many more influences than the SPRME would suggest. Exposition of this required me to consider a methodology which is able to reveal and resolve the subject positions taken up by students. Here, in contrast to the words of the SPRME the experience of doing and being a student midwife is of interest. This with the aim of highlighting differences, complexities, contingencies, forces and effects in relation to emergent professional identities and thereby creating opportunities to explore, detect and create possibilities for learning and change.

Ball (2013, p.6) suggests, in his analysis of educational policy, that Foucault was 'interested in the ways in which power flows through architecture, organizational arrangements, professional expertise and knowledge, systems of classification and "dividing practices", therapeutic procedures and how it comes to be written onto bodies and into our conduct'. The purpose of which is to point out 'what kinds of assumptions, what kinds of familiar, unchallenged and unconsidered modes of thought the practices that we accept rest' (Foucault and Kritzman, 1988, p.154). It is, therefore, not a thesis that seeks a definitive answer but one that aims to disentangle some of the threads that weave together current understandings of learning in the practices of midwifery education.

As for Foucault, he exerts power on the passages of this thesis, but at the level of the back-seat-driver. Mainly on account of his being more of an ideas man than an action man.

Rationale for the study

Preliminary searches of the literature yielded no return in relation to the analysis of policy discourse and the construction of midwives' identities. Aspects of professional practice required by the NMC in the Standards of Pre-registration midwifery education (NMC, 2009) such as accountability, autonomy and responsibility are explored in the literature (Scamell and Alaszewski, 2012; Skirton *et al.*, 2012; Healy, Humphreys and Kennedy, 2016; Skinner and Maude, 2016) but not as constituting identity. The construction and enactment of professional identity is successfully explored by Divall (2014) with regard to midwifery leadership; however, this does not address the experiences of student midwives. Exploration of the experiences of being a student midwife, and how certain facets of professional behaviour emerge in relation to this, are more broadly discussed (Skirton *et al.*, 2012; Fullerton *et al.*, 2013; Chenery-Morris, 2015; Einion, 2016; Nolan, 2017), but there is nothing that examines this as an effect of discourse or as identity constructions *per se*. For these reasons I understood there to be a gap in the literature which provided the initial justification for my thesis.

The statutory and regulatory context of midwifery education and practice

In midwifery education, UK government policy is operationalised through the regulatory frameworks articulated by the NMC. Although at the time of writing there is great concern in the midwifery community that from October 2020 there will be no midwifery representative on the NMC Council (RCM, 2020).

Accountable to Parliament through the offices of the Privy Council, the NMC is charged with the regulatory responsibility to:

- maintain the register of nurses and midwives who meet the requirements for registration in the UK and nursing associates who meet the requirements for registration in England

- set standards for education, training, conduct and performance so nurses, midwives and nursing associates can deliver high-quality care consistently throughout their careers

- take action to deal with individuals whose integrity or ability to provide safe care is compromised, so that the public can have confidence in the quality and standards of care provided by nurses, midwives and nursing associates (NMC, 2020c, p.6).

It is from these regulatory frameworks that much of Scottish national, [through the Quality Assurance Agency for Higher Education Scottish Subject Benchmark Statement – Midwifery 2009] (Education and Scotland, 2009) and local level (Approved Higher Education Institution) educational policy relative to midwifery is derived; such is the strength of authority held by the NMC, who also audit provision in respect of their standards. This power, devolved in respect of policy and practice through the SPRME (NMC 2009), has been a source of criticism (RCM, 2015) and has led to recognition that change is necessary if the rhetoric of ‘efficient and effective regulation’ (NMC, 2015) is to be achieved. These processes could significantly alter the scope of midwifery

practices and have considerable influence on the content and provision of midwifery education (RCM 2015).

As previously mentioned, the NMC 'exists to protect the public' (NMC, 2017); however, in the 'Forward' of its 2019 Annual Report (NMC, 2020c) it acknowledges its failings in the handling of midwives' fitness to practise at Furness General Hospital[1]. As the independent regulator charged with protecting patients and the public this seems an ominous start to a reporting cycle. Alongside protecting patients and the public, the NMC is tasked with the setting and promotion of standards of education and practice, maintaining a register of those who meet these standards, and taking action when a nurse's or midwife's fitness to practise is called into question.

The standards for midwifery education in use at the time of writing were published in 2009, there was significant delay to the development of new standards, which were predicted to be published in 2017, and were made available to the public in November 2019. These new standards will be implemented in September 2021 in Scotland.

[1] 'The Morecambe Bay Investigation was established by the Secretary of State for Health to examine concerns raised by the occurrence of serious incidents in maternity services provided by what became the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust), including the deaths of mothers and babies. Relatives of those harmed, and others, have expressed concern over the incidents themselves and why they happened, and over the responses to them by the Trust and by the wider National Health Service (NHS), including regulatory and other bodies' (Kirkup, 2015, p. 7).

The social and historical context of midwifery education and practice

The current midwifery policy context is heavily determined by its social and political history and the discursive practices therein. To understand how 'midwifery' and 'midwives' as discourses have emerged it is important and necessary to explore some of the processes by which the regulated occupation of 'midwifery' came into being.

In the eighteenth century, the birth environment as a site of professional struggle emerged with gender politics and power as central themes (Landry and MacLean, 1990; Thomas, 2009) and much bickering to boot. The rhetoric of the time left little unsaid as to how professional rivalries were understood. In 1760, midwife Elizabeth Nihell describes a prominent obstetrician of the time, William Smellie, as being 'trained up at the feet of his artificial doll' and goes on to describe 'those self-constituted men midwives made out of broken barbers, tailors or even pork butchers; for I know myself one of the last trade who, after passing half his life stuffing sausages, is turned an intrepid physician and man midwife' (Nihell cited by Malins, 1901, p.1530). Continuing the sniping in 1772, obstetrician Louis LaPeyre describes the midwife as 'an animal with nothing of the woman left' (Cody, 1999, p.477) and almost a century later in 'An Introductory Lecture on Midwifery' obstetrician J.G. Swayne cautions in 1846 that:

> although some women have attained so just a celebrity in obstetrics, yet any unprejudiced person will say at once, that it is an art which requires both the head of a man to comprehend its principles and the hand of a deficient in that degree of cool judgement, combined with fortitude and

> power of endurance, which are so necessary for the more difficult operations of midwifery (Swayne, 1846).

Somewhat missing the irony that 'the weaker sex' need a bit of fortitude and endurance during the process of being 'mid-wifed'. This historicity is significant to the discussion in that that these debates prevail over time and eventually give rise to the statutory regulation now in force.

Regulating practices

The regulatory story begins towards the late nineteenth century when the 'untrained' and 'unregulated' midwife or 'Howdie' as described in Scotland (Reid, 2008) increasingly gave cause for concern amongst the burgeoning nursing and medical 'professions' (MacDonald, 1995). Despite certified programmes of midwifery education being available, which only relatively affluent women would be able to afford (giving access to the prestigious 'Midwives Institute') it was the practices of the working-class lay midwives that were to come under the closest scrutiny. This was an issue borne not only of the struggle for male-dominated medical professional autonomy in childbirth, but also of class and status between lower, and middle and upper-class women. As Heagerty (1997, p.73) describes:

> In matters pertaining to the working-class midwife and the women they attended, the Institute members expressed more kinship with those of their class – men and women, medical or lay – than with the women of the working class.

Somewhat at odds with the ‘principles of feminism and the struggle for suffrage’ inherent in social reform and the lives of (some) women at this time, Heagerty (1997, p.73) presents a terrain where imperiousness and moral judgment on the part of medical men and the women of the Midwives Institute led to the imposition of a system of education and governance upon lay midwives that ultimately shifted the direction for all involved.

At the turn of the nineteenth century, market forces and the rise of new knowledge and technology provided fertile terrain for would-be professions. Medicine’s reluctance to take on the ‘time-consuming and boring’ (MacDonald 1995, p.146) work of midwifery created an opportunity for midwives to try to capitalise on this work as a legitimate role and emerge in the context of a ‘profession’. In the contest for professional autonomy and the development of a statutory ‘Midwives Board’ it was hoped that registration would bring market control and status. Midwifery suffered defeat at the hands of medicine; the Central Midwives Board [CMB] established by the Midwives Act of 1902 contained no midwives, just one doctor as their representative. Such was the resistance of midwifery in Scotland at the time, the corresponding Act did not come into being until 1915; but similarly, the CMB for Scotland made training, examination and registration for midwives compulsory.

As an exercise in maintaining professional authority, the power of medicine was sufficient to ensure that the practice of midwifery conformed to standards that it was integral in the approval of. Witz (1992, p.130) argues that existing gendered discourses relating to the work of ‘medicine’ as masculine and ‘nursing’ as female enabled doctors to separate the ‘normal’ women’s work

from the complex, interventionist male domain. ‘A midwife who knew when to send for the doctor’ was the first goal of the regulations formulated by the Central Midwives Board’ (Heagerty, 1997, p.75). A separate set of legislation was developed at the time of the 1902 act to ensure that midwives were adequately ‘supervised’ concerning standards of practice and behaviour. This was also in the interests of ‘social improvement’ – moving the image of the Dickensian, gin-swilling midwife Sairey Gamp forwards into respectability. Responsibility for this was tasked at county council level in the form of a Local Supervising Authority (LSA). Evolving from the authoritative monitoring of education, hygiene, surveillance of practice (including personal practices) and fitness to do so, this supervision has latterly been undertaken by the NMC and its fitness for purpose in respect of this has come under a great deal of scrutiny (Kirkup, 2015).

The Central Midwives Board for Scotland was responsible for the training, examination and registration of midwives until 1983, before this the Nurses, Midwives and Health Visitors Act (1979) stipulated the unification of Nursing, Midwifery and Health Visiting regulation under the umbrella of the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) (Heagerty, 1997). Changing the boundaries of governance from individual professions to a unified regional body, it aimed to maintain a public register of nurses, midwives and health visitors and to monitor programmes of education and training. In effect midwifery regulation at this point swapped a domineering big brother for an equally bossy big sister. Midwives are alleged to have dragged their heels to agreement on this policy, and are still chastised for years of delay in the introduction of the act: ‘this was due to the need to take account

of …… lack of consensus within the professions (especially from midwives)' (NMC, cited by Mander and Murphy-Lawless, 2013, p.59).

Interestingly, the document from which this quotation is derived is no longer available on the NMC website. Time served, perhaps; however, at the time so concerned were midwives with the potential subsumption of professional identities that a pressure group was formed 'the Association of Radical Midwives [ARM]' whose aim was to politicise the midwifery agenda and protect the role and function of midwives (Mander and Murphy-Lawless 2013).

It is important to note that around this time two routes into midwifery opened up. Up until the mid-1980s midwives in the UK completed a nursing qualification and then having practised for a time would apply to and complete a certified midwifery course (Mander, 2009). The move into academia was in part a response to the discourses of 'professionalism' aimed at raising the standards of knowledge and competence (Eraut, 1994) required of the 'profession' of midwifery. This required a move up an academic level from diploma level to an all-graduate profession. It also coincided with the emergence of the concepts of risk, evidence-based-practice and medico-legal discourses (Wendland, 2007; Spendlove, 2018). Humes (1997, p.25) suggests that the 'emphasis on competence-based qualifications, transferable skills and applied knowledge is entirely compatible with the "grand narrative" of emancipation through scientific progress linked to economic success. Midwifery education has become 'emancipated' with current provision in the UK including Masters level pre-registration programmes.

The diploma and degree awards offered to pre-registration candidates by HEI's changed the landscape of nursing and midwifery education creating inter-professional tensions along the way. I recollect an occasion where a woman was told (over them as they lay in bed) 'don't listen to her, she's not a nurse and she doesn't know what she is talking about'. The balance, however, has shifted. Now the Scottish Government provides more funding for pre-registration places than for post-registration. As such, most of the midwives that have registered in Scotland in the past fifteen years have not previously been a registered nurse. There are currently 37,255 registered midwives in the UK, 660,213 nurses and 7,296 dual registrants (NMC, 2020b).

Accused of failings in respect of disparate governance and a lack of cohesive standards, the UKCC was abandoned in 2002 in favour of a new regulatory body, the Nursing and Midwifery Council (NMC). Proposed as a means to offer more rigorous and cohesive safeguarding of the public interest and established under the Nursing and Midwifery Order 2001 (this is an important piece of legislation as it details the specific role and function of a midwife – the significance of which will be discussed later). The most recent NMC annual report (NMC, 2020c, p.5), suggests that as a regulatory body the NMC still much to account for, it states that 'serious concerns were raised about how it handled concerns about midwives' fitness to practise at Furness General Hospital'. Further, it acknowledges that the approaches used and the ways that people involved were treated was 'unacceptable'. The rhetoric of regulatory practice then acknowledges that 'through our new approach to fitness to practise, we are taking greater account of the context in which mistakes occur' (ibid), a clean slate it would appear.

The NMC is governed by a Council of twelve members, selected through open competition, it describes itself as being ‘made up of twelve members: six lay people and six nurses or midwives’ (NMC, 2020a). A midwifery committee, which convened for consultation in respect of midwifery matters was discontinued in 2017, which means at the point of writing there is no specific midwifery voice in the NMC (RCM, 2020). This issue is relevant in that there has to be representation for midwives to protect both them and the women and families in their care. If the profession of midwifery is different to that of nursing, then there must be representation from midwives at this strategic level.

Background

What is a midwife?

In the UK, midwifery is recognised in law as a profession that has a ‘protected function’ (NMC 2017, p.9). Alongside registered medical practitioners and their students, midwives and student midwives under their supervision are the only people who can attend legally attend women in childbirth (in the exception of a ‘sudden or urgent necessity’ - heaven forefend). The title ‘midwife’ is protected in the law and it is an offence to use the term unless recorded on the NMC’s register as a ‘midwife’.

Formal midwifery discourses such the ‘Standards for Pre-registration Midwifery Education’ (NMC, 2009, p.4) which mandate the regulatory requirements of the Nursing and Midwifery Council (NMC) present the ‘international definition of a midwife’. This tells us what midwives have been globally agreed to ‘be’ by the authority of the International Confederation of Midwives (ICM), the International

Federation of Gynaecology and Obstetrics (FIGO) and the World Health Organisation (WHO). As such 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 post-partum 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.

From here, the standards go on to describe how this midwife should emerge through the processes of professional learning and clinical practice. Appraisal of this definition of the midwife starts to reveal some of those patterns and representations, particularly with how this description 'constructs' midwives. For example, what it means to be responsible, accountable and professional in the contexts within which this definition applies.

Informal discourses such as Wikipedia (no date), state that a midwife is 'a health professional who cares for mothers and newborns around childbirth'. This statement is followed by: 'the education and training for a midwife is similar to that of a nurse, in contrast to obstetricians and perinatologists who are physicians (doctors)'. A midwife in this context then, rather than being described in relation to the behaviours expected of them, is articulated in relation to others: similar to a nurse, definitely not a doctor.

I am not a nurse or doctor. I have often been called the former, but never mistaken for the latter. In respect of this as an existential question, Foucault suggests that a subject (a midwife) is constituted by 'all that was said, in all the statements that named it, divided it up, described it, explained it, traced its development, indicated various correlations, judged it and possibly gave it speech by articulating in its name discourses that were taken as its own' (Foucault, 1972, p.32). The question asked by this thesis, therefore, relates to how the midwife as a subject is constituted in the discourses of policy and professional practice and how these discourses are taken up or resisted in respect of the creation of an autonomous, agency bearing professional.

And what is midwifery?

When considering the future direction for the midwifery profession in 2010, the Midwifery 2020 Programme (a UK wide collaborative of health departments) proposed a vision and a framework for the development of maternity services it urged that midwifery educationalists:

> ensure pre-registration curricula are fit for purpose to educate the midwives of the future to work in a range of settings and combine normality with the reality of the future
>
> (Chief Nursing Officers of England Northern Ireland Scotland and Wales, 2010, p.12)

Midwifery then is predicted as taking place in multiple settings and will combine normality with the 'reality of the future'. The future is not real, it is imagined. If, however, it has to be combined with normality the 'reality of the future' is

seemingly something that is not ‘normal’. Educationalists need to prepare the midwives of this future to be ‘fit for purpose’ regardless of what this means.

The vagaries of the ‘reality of the future’ notwithstanding, ensuring ‘fitness for purpose’ relative to this is difficult, as it is the Nursing and Midwifery Council (NMC) who set the standards for midwifery education that Approved Educational Institutions (AEI) must abide by. The NMC is the statutory and regulatory body who protect the public by setting standards for education, conduct, training and performance for midwives and nurses (NMC, 2009). In setting these standards, there are issues raised in respect of the power and authority the NMC has to determine who and what it anticipates midwives should be. In the SPRME (NMC, 2009, p.6) it is suggested that education prepare students to accept ‘personal responsibility for their own ethical choices… based on their own professional judgment’; to ‘assume full responsibility for their practice as midwives’; to be a ‘responsible and accountable professional’.

Again, what it means to be ‘responsible’, ‘accountable’ and a ‘professional’ is open to question (Eraut, 1994; Evetts, 2003; Scanlon, 2011; Fenwick, 2016) and raises issues about standards that seek to create that which is ‘fit for purpose’. In contrast to the NMC’s polished, complete practitioner, Scanlon writing in relation to ‘Becoming a professional’ (2011, p.14) contests that ‘final expertise is unachievable’, and that ‘not only the professional but professional practice is an iterative cycle of becoming other.’

A critical and reflexive appreciation of the meaning of statutory responsibility and accountability can be overshadowed by regulatory frameworks that

foreground competence, skill and the somewhat nebulous, but prized, concept of ‘employability’. Trede, Macklin and Bridges (2012) propose that criticality about being, thinking and acting contribute to what knowing what one stands for in terms of professionalism; this raises questions relating to how midwives’ identities come to be shaped (Eraut, 1994; MacDonald, 1995; Cetina, Schatzki and Von Savigny, 2005), and whether a critical view of the processes implicated in the construction and performance of identities is a necessary part of this. The nature of professional and educational discourses and their impact on the construction and performance of midwives’ identities are not described in the literature. This gap provides an opportunity to explore possibilities for development and change at a time of relative uncertainty as to what it means to have a ‘professional identity’ in midwifery.

The aims of the thesis

This thesis aims to question what is taken for granted about midwives’ identities. I aim to explore the ways in which the discourses of policy, professionalism and learning construct midwifery identities as ‘social realities’ (Fairclough, 1992, p.169) and consider how these social realities are taken up or resisted within the discourses of student midwives as they construct and perform *their* professional identities. Through this questioning of what is taken for granted about midwives’ identities I aim to provide useful commentary and perspectives with which to inform future practice. Professional identity is linked to self-esteem, self-efficacy, professional value, confidence and success (PSA, 2016). Where there is a lack of professional identity the opposite applies. Aspects of professional identity are also fundamental in the provision of safe

and effective care (Knight *et al.*, 2019). It is important for these reasons that midwifery policy, learning and practice is informed by contemporary understandings of how professional identities are formed.

Research questions

Drawing from the theoretical perspectives of discourse, narrative and visual analysis, there is one overarching question, three sub-questions and one methodological question.

The overarching research question asks:

What are the discourses within which student midwives' professional identities are constructed and performed and what significance does this have for professional learning and practice?

The three sub-questions used to explore this are:

1. How are student midwives constructed in the discourses of policy, professionalism and learning?
2. How do student midwives position themselves in relation to these discourses?
3. In what ways are these positions implicated in the construction and performance of their professional identities and what significance does this have for practice?

The methodological question asked is:

4. In what ways can the inclusion of gesture contribute to the development of small story analysis?

Exposition of the overarching research question uses three approaches to qualitative inquiry. These are: discourse analysis, narrative analysis and the

analysis of gesture. Erickson (2004, p.487) helpfully describes qualitative inquiry as that which 'wonders about the kinds of things (and kinds of kinds) that are relevant to local social actors in the routine conduct of social interaction'. My research is interested in several 'kinds' of things and therefore requires different, but complementary approaches. Sub-question one aims to identify how midwives are constructed in the discourses of policy, professionalism and learning, and uses discourse analysis methods proposed by Fairclough (1992). The second question is explored empirically through narrative analysis and uses 'positioning' and 'small stories' (Davis and Harré, 1990; Bamberg and Georgakopoulou, 2008). The methodological question explores how the analysis of 'positions' and 'identities' may be enhanced through the additional lens of 'gesture' through my own 'micro-dramas'.

The structure of the thesis

Chapter 2 presents contextual aspects of discourse and identity and how they are understood in the literature. I provide a discussion of contemporary perspectives of midwives and midwifery. I then provide an appraisal of the literature concerning identity and midwifery. In the main, the focus is on UK studies in relation to education and professional practice, however, a discussion of wider literatures considers other theoretical framings.

Chapter 3 explains the methodologies used to answer the sub-questions in turn. Here I discuss discourse analysis, positioning, small stories and micro-dramas as the methodological threads that bind the piece together. I provide a discussion of the literature that informed the basis for theorisation of micro-

dramas and the framework that was developed to implement this; both as a contribution to knowledge and as a new methodology.

Chapter 4 discusses the research strategy, provides a description and a rationale for the research setting, and a discussion of the processes that informed my decision making for the methods used to answer the research questions.

Chapter 5 provides a discourse analysis of the Standards for pre-registration midwifery education [SPRME] (NMC, 2009). I explore the document at the level of discursive practice, at the level of the text and the level of social practice using Fairclough's (1992) three-dimensional conception. I justify the use of concepts such as interdiscursivity, intertextuality, modality, ideology and hegemony in relation to this.

Chapter 6 provides an exemplar from empirical data collected in response to sub-questions 2 and 3. I present a full small story and micro-drama transcript and analysis. The aim of this is to provide one participant's analysis in its entirety so that the process for the analysis of each participant is presented.

Chapter 7 presents a corpus of instances drawn from all the participants to illustrate aspects of identity. This proposes the themes 'Insiders and outsiders', 'Transitions and confidence', 'Competence', 'Responsibility and accountability', 'Being woman/midwife' arising in the empirical data in relation to the construction and performance of the student midwives' professional identities. I use 'frames' developed as part of the micro-drama methodology to explicate these themes and consider them in relation to Chapter 6 and the analysis of the SPRME.

Chapter 8 relates the policy analysis in Chapter 6 to the empirical data and emergent themes from Chapters 7 and 8. In doing so I answer my research questions, bringing together the ways in which policy constructs midwives and the ways in which the student midwives discursively construct themselves and their professional identities. The performance of identity is incorporated into this discussion and addresses the ways that the analysis through the micro-dramas has contributed to and developed small story analysis. I end the chapter with the strengths and limitations of the study and my contribution to knowledge.

Chapter 9 concludes the thesis in the context of 'powers, passages and passengers' and suturing the concepts together with a glance back at Foucault. I also present a discussion of the implications for practice and future research.

Conclusion

In presenting the motivation and aims of the study I propose the exploration of what is taken for granted about professional identity in the context of midwifery education and practice. The background, context and rationale provide a pre-emptive foray into the socio-political and historical influences that give rise to the discourses within which midwifery practice is currently nested, and the chapter outline gives an indication of how the thesis is structured.

Chapter 2 - Defining and exploring discourse and professional identity in the literature

Introduction

This chapter has two aims: to present the epistemological assumptions relating to how ‘discourse’, ‘identity’, ‘construction’ and ‘performance’ informed and shaped the development of the thesis; and to explore concepts of professional identity in the literature in general terms and then more specifically in relation to midwives and midwifery. Combined, the outcomes of these aims provide the justification for the theoretical perspectives which underpin this study, and reveal the gap in knowledge pertaining to the construction and performance of midwives’ professional identities that this thesis addresses.

What is a discourse?

The study aims to examine midwifery education and practice through a social constructionist paradigm. This paradigm questions concepts of ‘truth’ ‘reality’ and ‘knowledge’ and offers a means to explore how discursive constructions of power, contingent in the shaping of the social world (Laclau and Mouffe, 2015) impact on taken for granted social structures and individual and social identities.

According to French philosopher Michel Foucault, discourses are:

> practices that systematically form the objects of which they speak…Discourses are not about objects; they do not identify objects,

> they constitute them and in the practice of doing so conceal their own invention (Foucault, 1972, p.49).

Foucault offers a perspective from which to explore how identities, relations and systems of knowledge and power are established and maintained in the social world. Although one of the many challenges of using Foucauldian approaches arises from his seeming reluctance to exemplify a discrete methodology for the analysis of discourse. Ball (2013, p.3) suggests that Foucault's 'intellectual project rested on seeking to find a space beyond traditional disciplinary or theoretical positions, from which he could subject those positions to analysis and critique, and from here trouble the "inscription of progress" in modern politics and scholarship'. Here Ball's quotation gives, in part, a rationale for having Foucault 'in the back seat' of this project as it provides a useful methodological distinction between the use of Foucault as a means to 'trouble' the SPRME without a priori assumptions and the processes which have a more distinct methodology.

Fairclough (1992) draws from the theoretical perspectives of Foucault and proposes that we view the analysis of discourse using a three-level framework. This explores discourse at the level of the text, at the level of discursive practice and the level of social practice. This is to understand how power and knowledge come together as policy and practice; and for this thesis, the implications that this has for the constitution of 'midwives' and 'midwifery'. Here, the power and knowledge in question relate to the statutory and regulatory policy of the Nursing and Midwifery Council (NMC) and how this manifests at the three levels proposed by Fairclough. The subjects under scrutiny are the

student midwives that evolve in and through the discourses set out in these policies. While this is the means used to explore how the discourses of policy and practice construct midwives, different approaches are used to gather empirical data relating to how students construct and perform their identities as 'midwives'.

The analysis of discourse is complex, not only in respect of how it is variously (and widely) described and theorised, but also in the ways in which is can be employed methodologically. Despite this, Bamberg *et al.* (2011) propose it as being 'the place par excellence for negotiating categorical distinctions with regard to all kinds of identity categories'.

In countering some of the challenges of discourse analysis, Gee (2014, p.7), gives helpful 'thinking devices' for inquiry in the form of 'big-D' and 'small-d' discourses. The former termed as 'social discourse theories' that is: 'frames within which social life is understood' (Bamberg *et al.*, 2011, p.181); the latter being 'language-in-use', or the 'local in situ contexts within which subjects find themselves speaking'. The distinctions between these discourses and their connections in relation to identities are presented by Bamberg (1997) as 'positioning theory' using narratives or 'small stories' as the means of data collection. I further this with the use of my own 'micro-dramas', a visual method which adds a new perspective from which to explore small stories and identities in the making. This development adds new knowledge to the identity work through the collection of visual data and will be discussed in more detail in Chapter 3. In respect of the research questions this thesis asks, the analysis of

big-D and small-d discourses is explored empirically using critical discourse analysis, positioning theory, small stories and micro-dramas.

Constructing and performing identity

Critical to the epistemological stance of this thesis and my interpretation of identity is the understanding that there is no 'silent, untroubled, normal or natural identity' (Lawler, 2015, p.2). This 'traditional scholarly view' (Bucholtz and Hall, 2005, p.587) situates identity as in the mind of the individual, and although this is understood as an aspect of identity, Bucholtz and Hall add that 'the only way such self-conceptions enter the social world is via some form of discourse.' Vignoles *et al.*, (2011) present identity as a concept widely discussed in studies of the social world; because of this they suggest multiple perspectives of the meaning of what it is to have an identity, and where this identity comes from.

Concerning social constructivist concepts of identity, Giddens (1991, p.35), amongst others who have problematised the issue (Du Gay, 2007; Butler, 2011), offers 'knowledge of what one is doing and why one is doing it' as a definition. Though it could be argued that there is more than 'one' at stake. Big-D discourse theorists such as Laclau and Mouffe (2015) might contest that 'one' is not in control of the forces giving rise to identity; positioning discourse as constitutive of identity, suggesting that from this all meaning is derived. Fairclough (2010) argues that this is not sufficient in explanatory terms and proposes the analysis of identity at two levels, that of discourse using discourse theory, and that of the social, using relevant social theory. It is acknowledged that there are epistemological and ontological differences between the theories

of Laclau and Mouffe and Fairclough (Jørgensen and Phillips, 2002). The derivations of these differences relate to perspectives of social constructionism and in interpretations of structuralist Marxism, the former believing that discourse is entirely constitutive and the latter proposing a dialectical relationship between discourse as constitutive, and as being constituted by other social factors. The key difference is the perception of agency afforded to the subject in terms of possibilities for identity.

Addressing issues of agency, Vignoles *et al.* (2011, p.10) suggest that individuals 'make up their identities as they go along' and makes the claim that 'people are not necessarily aware of the identity processes that are at work'. Bamberg *et al.* (2011, p.7) recognise that identities are 'made up' in the context of wider discourses and extend the discussion as to how this 'construction' takes place. Here, identity is not essentially framed as what it 'is' but rather they claim that their suggestion 'implies a shift away from viewing the person as self-contained, *having* identity and generating his/her individuality and character as a personal identity project toward focusing instead on the processes in which identity is *done* or *made* – as *constructed* in discursive activities' (ibid).

The distinctions between discourses in relation to identities, and their construction at the level of the individual are brought together by Bamberg (Bamberg, 1997) using Davis and Harrés' (1990, p.62) concept of 'positioning'. Positioning is understood as: 'the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines' (ibid). This is with the aim of developing understanding of 'how it is that people do being a person'. This description

references the ‘conversation’ and ‘story lines’ as the site for analysis and as such requires research methodologies that collect appropriate data. Recognising that there were possibilities for the development of positioning in respect of this, Bamberg and Georgakopoulou (2008) explore the use of narratives as a mechanism for identity analysis in relation to ‘big’ and ‘small’ stories. Big story accounts offer ‘more or less unmediated and transparent representations of the participants’ subjectivities and from there as reflecting back on their identities’ whereas small stories are ‘how people actually use stories in every-day, mundane situations in order to create (and perpetuate) a sense of who they are’ (ibid, p.1). Having listened to student midwives reflecting on their experiences of becoming midwives both in the university and in clinical practice over many years it was of interest from a research perspective to see how small stories could be used as a methodological entry point to the construction and performance of identity.

‘Performance’ of the self has also been the subject of extensive theoretical debate. Goffman’s (1978, p.28) sepia tinged perspectives on the manifestation of identity and the performance of such, continue to thread through contemporary discussions of the ‘presentation of the self in everyday life’. The performance of identity for him is exemplified as follows:

> When an individual plays a part he implicitly requests his observers to take seriously the impression that is fostered before them. They are asked to believe that the character they see actually possesses the attributes he appears to possess, that the task he performs will have the

> consequences that are implicitly claimed for it, and that, in general, matters are what they appear to be (ibid).

Gendered pronouns notwithstanding, he goes on to state that 'At one extreme, one finds that the performer can be fully taken in by his own act' yet he counters that 'At the other extreme, we find that the performer may not be taken in at all by his own routine' (ibid). These differing perceptions of the performance are arguably constructed in and through discourse. Judith Butler (1993) extends 'performance' into the concept of 'performativity', and while her theorisation of this relates to sex and gender, its reach extends beyond this perspective. Performativity is the means by which 'utterances…make something happen' (Lawler, 2015, p.128), for example the student midwife who performs her identification with this term when she is named as such. Lawler (2015, p.135) contends that both Goffman and Butler see identity as 'done rather than owned'. The 'performance' of identity that emerges from discourse is therefore also key to the perspectives that this thesis takes and as such requires a means to address this.

In summary, identity as a concept is robustly articulated by Bucholtz & Hall (2005, p.606) they conceptualise it as follows:

> *'*any given construction of identity may be in part deliberate and intentional, in part habitual and hence often less than fully conscious, in part an outcome of interactional negotiation and contestation, in part an outcome of others' perceptions and representations, and in part an effect of larger ideological processes and material structures that may become

> relevant in interaction. It is therefore constantly shifting both as interaction unfolds and across discourse contexts*'.*

This description is relevant to this study in that it considers issues of construction and performance from both Big-D and small-d discourse perspectives; it also presents identity as fluid and temporal. Moreover, Bucholtz and Hall (2005) reinforce the importance of research that considers multiple perspectives of identity construction, as this project aims to do. In this thesis therefore, the definition of identity is predicated on Bucholtz and Hall's (2005, p.586), who succinctly describe it as 'the social positioning of the self and other'. On account of the broad theoretical field which informs their definition they describe it as being 'deliberately broad and open ended'.

The significance of identity as a concept, Watson (2006, p.509) suggests 'lies in its relationship to professional knowledge and action'. In respect of midwives' identities, professional knowledge and action are implicated in the provision of safe and effective care (PSA, 2016; Scottish Government, 2017; Knight *et al.*, 2019) and therefore provide a rationale for this project. All of which offers an opportunity to explore how midwives' construct and perform 'identities' and what this means in the context of professional knowing and being.

Professional Identity and midwifery in the literature

A significant aspect of this thesis is concerned with the type of midwife that a student midwife becomes. This issue is not easily resolved, it also engenders further enquiry, raising issues such as how does a person become a midwife, what are the forces that shape this becoming, and what structures do learning

theories offer in support. There are arguably no definitive answers to these questions and the subjective nature of my interpretation of these issues may well differ to that of others; however, as the care of women and their families depends on how successfully these transitions take place, there can be no denying their significance. This is reinforced with the perspectives of identity that my thesis adopts, that identity is the 'social positioning of the self and other' (Bucholtz and Hall, 2005, p.586) and provides grist for the mill for my study.

I begin with a review of the literature which addresses 'professional identity', relevant to research question one and the 'discourses of professionalism'. Understandings of identity in the context of midwives and midwifery are then considered as a means to explicate research questions one, two and three, I then discuss how other theoretical understandings of midwifery are presented in the literature. I finish the chapter by considering how education and practice have contributed to the literature in respect of midwives' identities and conclude with a discussion of the implications this has for my research.

Professional identity

The meaning of what it is to be a 'professional' is ground that has been extensively trodden in the literature. MacDonald (1995) proposes that if the state is the 'omnipresent external feature of the professional project, the '*sine qua non'* of its internal structure is knowledge'. As an outsider to Latin (used rhetorically to reinforce *his* professional status), a Google search revealed that knowledge is essential in the construction of professional identity. Professional status therefore relies on esoteric knowledge (Benoit, 1989, p.160; Eraut, 1994) to assert and reinforce claims to power. Where there is tension, for example in

subjugated spaces occupied by some professionals (see Etzioni, 1969 for an extensive discursive construction of the 'semi-professional' teacher, nurse and social worker), there is opportunity to explore the ways in which identity is brought forth. Midwifery, as the perpetual adjunct to nursing and medicine occupies just such a contested space.

The construction and performance of professional identity is significant to broader socio-cultural understandings of who 'professionals' are and what they do. Significantly, it is also implicated in the development and enactment of policy, regulation, education and professional practice. Barker and Creary (2016, p.261) view 'an individual's professional identity as a subjective construction that is influenced by the interpersonal interactions individuals have with others about their work' and therefore, as a socially mediated activity. They also take the view that there are a 'plurality of identities' available at any given time. Conceptualising this in their theoretical integration and extension of identity work within the professions, Lepisto, Crosina & Pratt (2015, p.12) state that individual identities are 'inherently precarious, malleable, and ongoing activities that require action and ongoing construction or *work*'. They further this and acknowledge that identity 'work' is about 'doing' not just 'being' and outline three situational triggers that trouble this area: deprofessionalisation or erosion of the esoteric claim, jurisdictional disputes or the ability to claim sole control over solving particular problems, and value displacement or the politics of the marketplace in a previously vocational space. These three situational triggers are evident in the context of midwifery practice; where professional status is immersed in historical boundary disputes with nursing and medicine, where concepts like risk permeate every aspect of 'solving particular problems' (ibid)

and where the institutional and organisational imperatives of the NHS are the prevailing discourses.

Proposing that identity 'construction' and 'work' in relation to professional identity are interchangeable terms, they conclude their appraisal with recommendations for scholars in this field (ibid). They suggest that 'identity work itself' is often overlooked in the building of new theory, that 'little has been done to examine the role of desires, wishes and aspirations as triggers of identity work' and the ways in which explanations of identity often 'downplay emotions' (ibid, p22). This provides a useful conceptualisation of the topic and reinforces the justification for this study, and the construction and performance of midwives' professional identities as making a significant and meaningful contribution to knowledge.

Regulatory Identity

Concepts of professional identity and midwifery are not widely discussed in the UK literature, either in respect of students, or of qualified practitioners. There is also little evidence of recent debate. The Professional Standards Authority [PSA] (2016), who regulate the regulators for Health and Social Care (including the NMC) provide a literature review of professional identities concerning regulation. They account for the need to distinguish the difference between 'professionalism and professional identity' citing Wilson *et al.'s* (2013, p.370) 'how an individual conceives of him- or herself as a doctor, whereas professionalism involves being and displaying the behaviour of a professional'. Arguably, one can only 'be' and 'display' professional behaviour if there is an identification with that particular profession. This aside, they provide a useful

rationale for their review. Professional identity for the registrant is argued by the PSA to be linked to self-esteem, self-efficacy, professional value, confidence and success. Where there is a lack of professional identity the opposite applies. The PSA also propose that retention within professions is central to a strong sense of professional identity. At a time when more midwives are leaving the profession than entering, the imperatives of my study seem appropriate.

Midwifery and identity

The midwifery literature explored considers the UK perspective in the main. This is because the regulatory standards of practice and behaviour and the clinical standards of practice and behaviour are enacted in culturally determined ways. This is significant not only to the UK context but the national, local and interpersonal context too.

Autonomy and identity

While some of the literature does discuss aspects of midwives' professional identities, this is generally not the primary focus of the studies concerned. For example, Bluff and Holloway (2008, p.301) explore the 'influence of midwifery role models on the role that student midwives learn'. Their findings are suggestive of two 'roles' that emerge as salient, 'autonomous' practitioners who are deemed to be appropriate; and the 'handmaiden' to the doctor, felt to be an inappropriate role model for student midwives. Here 'role' is conflated with identity in respect of what subject positions students can occupy. Where students see 'autonomy' this is what is enacted. Where subservience is observed, this too is what is enacted. What is not clear from the study are the

temporal aspects of these identifications and how much of the ‘role’ adopted was relevant at a specific moment in time.

Much research related to ‘becoming a midwife’ is focussed on the ‘final year’ student. The point of transition is explored in the context of preparedness for delivering clinical care by Skirton *et al.* (2012). The study concludes that newly qualified midwives were equipped to work autonomously as practitioners but lacked confidence in key areas, and while these concepts are not specifically tied back to ‘professional identity’ they arise in similar contexts. Autonomy as a key concept threads through the literature as Rogers (2010, p.460), who explores the learning experiences of final-year midwifery students in the context of inter-professional learning, discusses. The findings give rise to a theme of ‘professional identity and understanding’ describing a perceived lack of ‘true’ autonomy and professional control by the participants, despite the ‘rhetoric from the profession’s body to the contrary’. Further, the study found that ‘students found the medicalisation, and perceived subservience of midwives to the medical model of care, in the acute learning environments, difficult to reconcile with the definition of a midwife as an holistic, autonomous practitioner and the expert in normality.’ This notion is progressed with recommendations that students ‘need to develop a secure professional identity to be able to engage fully with interprofessional learning’ and the recommendation that lecturers enable this to happen. While it is a useful study that highlights aspects of professional identity, it does not approach this with a specific focus on how identity is constructed and performed. The contradictory perspectives on the concept of autonomy found in each study are suggestive of a need to explore how autonomy comes to be constructed in midwives’ professional practice.

The concept of ‘professional autonomy’ (the meaning of which is undefined in the paper) is also the focus for Baird (2007, p.400) who explores the beliefs of a sample of senior midwifery students nearing registration. Her findings indicate that students felt their midwifery education had ‘failed to equip them for professional autonomy’ and that ‘they considered that the medicalisation of childbirth had prevented most of their mentors practising autonomous midwifery’. Baird acknowledges that there is little in the midwifery literature that conceptualises ethical principles such as autonomy, accountability and responsibility and suggests that it was unsurprising that the students struggled with defining the terms. It is also proposed that midwifery curricula are prepared to ‘cultivate autonomy in deliberation and reflection’ (ibid, p.402) but it is made clear that the most significant barrier to autonomy is medical dominance in the clinical environment. Healy *et al*. (2018, p.367) use a qualitative methodology to address midwives’ and obstetricians’ perceptions of risk and conclude that midwifery is in a ‘peripheral position with regards to normal birth’. They suggest that this is revealed in four themes; (1) professional autonomy and hierarchy in maternity care; (2) midwifery-led care as an undervalued and unsupported aspiration; (3) a shift in focus from striving for normality to risk management; and (4) viewing pregnancy through a risk lens. Although the research is not presented in a context of professional identity, their conclusion suggests that midwives’ ‘professional identity is in jeopardy’ because of these perspectives.

Developing their previous empirical work which has the concept of ‘risk’ as its focus (Scamell and Alaszewski, 2012; Scamell, 2014), discourse analysis is used in a study by Scamell and Alaszewski (2016, p.67) as a means to identify the ‘moral component of midwives’ discourses’. In doing so they highlight the

‘moral and ideological underpinning of midwives’ discourse (ibid p.81) and provide an example as to how this is implicated in professional identity. Where women make decisions that collide with the ideology of the midwife and/or institution this challenged the ‘right to authoritative knowledge’ that one participant felt. The analysis draws attention to the power issues that decision-making and risk raises, and the ways in which this can undermine professional confidence. Professional responsibility and accountability were also implicated with ‘ultimately, fear of blame’ (ibid, p.78). Of note is the finding that the midwives in their study were less likely to challenge those women who wanted more intervention ‘as this tended to go with the flow of their medicalised work’, and women who wanted less intervention ‘were treated as both a professional and personal threat and as women who were not behaving morally or responsibly’ (ibid, p.81). The concepts raised in these papers are central to the discussion regarding the construction and performance of professional identity and contribute to the rationale for this thesis.

Midwifery and education

In a study addressing how midwives’ surface professional knowledge in relation to their professional identity as mentors, Nicolini and Roe (Nicolini and Roe, 2014) explain that ‘a multiplicity of competing knowledge and abilities co-exist in uneasy tension behind the authoritative normative accounts produced to support the myth of a coherent and bounded professional practice’. This acknowledges the shape-shifting challenges for not only the emergent identities of students but also for their mentors. Their findings suggest that mentors are reluctant for the novice to become their ‘clone’ (ibid, p.79) but also acknowledge

the need for agreed standards against which performance is judged; this requires the creation of a balance between reinforcing the esoteric knowledge required of professional standards and the craft knowledge that arises in practice. Also voiced in their findings are midwives' concerns regarding authoritative knowledge and 'the spread of the medical model' heard in students' language and discourse. This causes questioning as to what influences these developments in student midwives and how it comes into being.

Exploration of the midwifery literature offers little discussion that questions the notion of midwives' professional identities and their emergence in and through midwifery education. In a comprehensive study of final year students' perceptions of learning to be a midwife in the UK, McIntosh *et al.* (2013, p.1179) suggest that there is a 'dissonance for some students who express the belief that there is a fixed and finite body of knowledge, without which they feel disempowered, anxious and ill-prepared for clinical practice'. This raises a further issue that juxtaposes the academic imperatives of professionalisation, the hierarchical constraints of the NHS as an organisation, and the students who perceive that 'a broad discursive education is a distraction from training in discrete clinical skills' (ibid). While McIntosh *et al.*'s (2013) research does not specifically address 'professional identity', the central concepts that they explore reveal aspects of this as constructed by the students in their study.

For student midwives, the hierarchies within the NHS manifest most closely in the 'mentor', those midwives who are responsible for supporting and verifying competence. Hughes *et al*'s (2011, p.477) use of a student quote 'there are

guiding hands and controlling hands', as a metaphor for good and bad practice experienced by student midwives, raises the issue of mentorship explored in their study. The students' uptake or resistance of practice behaviours as modelled by their mentors is proposed and is found to be contingent in the main on the professional relationship. Personality clashes could undermine confidence in the clinical environment where 'the impact that a mentor has on a student midwife's confidence and self-esteem is profound' (ibid, p.482); this notwithstanding the power that the mentor has to determine success or failure through the grading of practice (NMC, 2009). The ways in which student midwives experience mentorship can have a significant impact on their emergent professional identities within the clinical environment. Concomitant with this are the pressures that midwifery 'work' can exert on the emotional and psychological state of students and the implications that this has in shaping midwives.

More recently, a lens has been focussed on the experiences of student midwives in clinical practice and their mental health by the academy. This response relates to the growing awareness of the responsibility that academic environments have towards students not only for their educational experience, but also for their physical and mental safety. Subsequently, the resilience, coping strategies and mental health of student midwives has been the focus of several studies (Davies and Coldridge, 2015a; Beaumont *et al.*, 2016; Spiby *et al.*, 2018; Clohessy, McKellar and Fleet, 2019; Oates *et al.*, 2019) with language such as 'traumatic stress', 'burnout', and 'compassion fatigue' used to describe the experiences studied. Preparedness for these situations is proposed as a means to alleviate symptomology, although in the context of

midwifery educational practice, solutions such as simulation, role play, and skills practice present their challenges (Lendahls and Oscarsson, 2017; Nel and Geraghty, 2018). Here, in relation to adverse events, there is a preoccupation with the simulation of psychomotor 'skills and drills' (Coffey, 2015, p.31) training over the exploration of emotional and psychological factors involved in the provision of care. Behavioural responses to critical situations which require 'resilience' and 'coping strategies' are implicated in the construction of professional identity. In respect of this Du Gay (2007, p.53) proposes that we have no 'essence waiting to unfold itself but are instead remarkably malleable creatures whose capacities and dispositions are formed and reformed in the various spheres of life where we are placed and place ourselves'. This suggests the significance of pedagogic strategies with which to pre-empt problematic responses to challenging situations.

Midwifery and 'mentors'

Superimposed on these experiences are how students are inculcated in the practices of their mentors. Armstrong (2010, p. 14) who researched clinical mentors' influence on student midwives' clinical practice, suggests that with power dynamics, the students in her study were compromised in the clinical environment. Stating that 'many felt that by challenging their mentors they might jeopardise their clinical assessments and career prospects', she asserts that there is an insidious subjugation of students' practice arising in the processes of assessment in the clinical environment. While these research objectives explore what it is to 'experience' as outcomes, they do not further the discussion on how these subject positions arise from the discourse that they

are situated within. This does not, therefore, contribute to the construction and performance of the student midwives' professional identities overtly, but provides perspectives from which to surface issues such as this.

'Good' midwifery identities

Concerning qualified practitioners and professional identity, Byrom and Downe (2010, p.126) explore accounts of 'good' midwifery and good leadership in practice; elements of morality, virtue and 'superlative clinical capacity' were all included in the findings, but no evaluation of how these concepts are constructed and performed as aspects of identity takes place. Professional identity for midwives is presented as a by-product of another study examining resilience by Hunter and Warren (2013). They found that personal and professional identity is often intertwined, quoting one participant who states 'A midwife is what I am. It's written through my body like a stick of rock'. Here the midwife presents who she is rather than what she does as her professional identity. From here, a strong professional identity is discussed as enabling professional autonomy, and would be suggestive of being significant to central tenets of the midwifery 'profession'; a profession described by Spendlove (2018, p.23) as being at risk of 'deprofessionalisation', which she argues raises 'concerns for the future role and professional status of midwives'.

Taking their findings forwards into another study of midwives' experiences of workplace resilience, Hunter & Warren (2014, p.926) suggest new insights into 'the importance of a strong sense of professional identity' are revealed. Articulated in the discussion as a sense of 'the love of professional practice', 'belonging' to a 'family', as having a 'vocation', and again as personal and

professional identities being intertwined. Hunter & Warren (2014, p.926) also describe participants ‘making a difference’ and contributing to the ‘greater good’, suggestive of moral aspects of identity construction. The value of professional identity they suggest is significant in terms of how it is approached in an ‘educational’ context, yet no further exploration is offered as to how the identities presented are brought into being.

Central to the cultivation of appropriate professional identity is the concept of leadership. Divall (2014, p.271) questions the construction and enactment of professional identity and leadership roles in midwifery and reveals ‘the destructive nature of conflict within the professional group’. Also challenged by Divall (2014, p.239) are ideas of shared language and identity amongst midwives, where described are ‘significant variance in meanings of terms such as “midwife”, “management and leadership’. The important role played by wider organisational structures within which midwifery leadership is practised is raised and leads to ‘suggestions of a lack of understanding of the unique professional identity of midwifery’. Also proposed are the challenges of developing identity at an organisational level, and the ‘imperative for the profession to extend its discourse of ‘midwife’ (Divall, 2014, p.273). Considering that good leadership is concomitant with good midwifery (Byrom and Downe, 2010; Scottish Government, 2017), Divall offers insights into ways in which discourses are relevant in respect of this.

Thus far, the literature that explores concepts of midwives’ professional identity is mainly situated in a context of education and practice relative to an authoritative professional epistemology centred on positivist ‘scientific’

principles. Barnfather (2013, p.131) questions this and investigates intuitive knowledge as an ‘essential component of the art of midwifery’ and suggests that ‘intuitive knowledge while inbuilt, through education and experience is developed, rehearsed and honed, developing into tacit knowledge’. Tacit knowledge is argued to be implicated in the improvement of midwifery practice when combined with ‘education and research’. Although more difficult to explain, this understanding of midwifery practice is commonly found in anecdotes by midwives (Davis-Floyd, Pigg and Cosminsky, 2001; Davis-Floyd and Davis, 2018) and is relevant to the study of the construction and performance of professional identity as it arises in the situated and informal discourses which constitute practice.

Wider literatures and midwifery

The discourses of midwifery and medicine, and aspects of professional difference and control with regard to practice, have been and still are a central feature of arguments within the literature, particularly in relation to professional identities (MacDonald, 1995; Hunter *et al.*, 2008; Mander and Murphy-Lawless, 2013). Foley and Faircloth (2003, p.182) suggest that midwives at times:

> must balance a world of medicine and a world of midwifery. At times they distance themselves from medicine, reifying the theoretical polarisation of the two models. Yet at other times, they draw on a discourse of medicine, medical culture or medical collaboration as a resource to legitimise their own work and occupational identities.

Here, they propose medicine as a discursive resource for midwives, integral to the narratives constructed that give their profession validity; a position characterised by Davis-Floyd (2007) as that of the 'postmodern midwife'. While the work of Foley and Faircloth raises interesting issues, it does reflect a perspective of midwifery from the United States, one that contrasts with the United Kingdom on several levels, not least of which is its continued illegality in some States. The origins of this illegality are worthy of noting and are said to lie in a nineteenth-century de-skilling of midwives, driven by a 'burgeoning' obstetric profession (Foley and Faircloth, 2003, p.166). The contrasts of professional status, and indeed existence of midwifery as a profession at all, do offer alternative points from which to analyse Big-D and small-d discourses. Laclau and Mouffe (2015, p.79) discuss the ways in which dominant discourses subordinate others, and present the concept of 'hegemonic intervention' taking place where competing discourses collide and one prevails, giving rise to a new fixation of meaning; in respect of Foley and Faircloth's article, midwifery and medicine offer an example of this.

Midwifery education and clinical practice

Practice learning accounts for fifty percent of an awarded midwifery degree, one third of the classification of that degree, and arguably a far higher percentage of the meaningful (and not so meaningful) learning experiences that exist over the course of a midwifery programme (McIntosh *et al.*, 2013). Unlike nursing, from which parallels are inevitably drawn, midwifery practice in the UK is not only assessed, but also graded (NMC, 2009) which affords practice educators (mentors) the responsibility of assessing fifty percent of the awarded

degree. There are those who would contend that the grading of practice is both arbitrary and entirely subjective (Licqurish and Seibold, 2013; Longworth, 2013) reflective of what Scanlon (2011) describes as being embodied in the neo-liberal managerialising discourses that exist in regulatory frameworks.

Critics would also highlight the disparity between preparation and ongoing educational support of mentors for this role, with a lack of priority and resource being evident in this area; similarly, midwife teachers, their clinical competence and the relevance this has in practice, are also called into question (Wray and McCall, 2009; Collington *et al.*, 2012; Fraser *et al.*, 2013). This is often conceptualised as the intractable gap between theory and practice.

A common failing of midwifery practice (and theory) reported in the literature, relating to professional learning, is a lack of recognition of individual experiences and prior knowledge (Longworth, 2013). While this is not entirely consistent across student groups, each will still have *their* sense of their ideal identity constructed, from what Scanlon (2011, p.16) describes as 'their repertoire of possible selves' in part from their experiences, mentors, 'or the rich array of filmic (and other) representations in popular culture, all of which contain potential exemplars of desirable and, of course, undesirable possible selves'. Often this leaves us with a contradiction of what we see in our students, what we would like those students to be, and what they see in themselves and what they would like to become.

This suggested ambivalence by educators of the students' prior self is only one of many of the complex relational factors that impinge on the success of practice learning. Hager, Lee & Reich (2012) suggest that there is a play of

voices and bodies in respect of practice learning, but that this is co-located in aspects of materiality or 'dispositives' as described by Jäger & Maier (2009). The one thousand four hundred and fifteen individual competencies (required to be demonstrated by the student and countersigned by the mentor over the three-year educational period) demonstrate the ways in which the impact of material/dispositive structures are contingent to the creativity and fluidity in learning that should be encouraged in practice. Humes (1997, p.26) discusses 'professional competences' as also referring to 'knowledge, understanding, critical thinking and positive attitudes' and suggests this 'sounds promising, even bold, but in fact these qualities hardly feature in the subsequent list of competences, which are essentially task-related rather than analytical or dispositional'. In the midwifery practice documentation currently used, many queries come back from mentors in relation to the 'is able to discuss' competencies and how to evidence this in relation to 'doing'.

Fenwick (2016, p.16) attests to this and expresses a feeling of despair that:

> large amounts of policy and curricula for professionals' learning and assessment continue to be generated that use models long since debunked and abandoned by educationalists: de-contextualized individual competency, disembodied cognitive decision-making, and de-materialized knowing and practice.

This could be argued to summarise characteristics of current midwifery educational curricula (the aforementioned regulations) which emerge from an increasingly audit driven culture, focusing not on quality, but on measuring and avoiding risk and the passing of the accountability parcel.

By constraining the mechanisms within which students (and mentors) can explore meaning in practice education, the ‘exoskeletons of power’ (Hager, Lee and Reich, 2012, p.4) that maintain and reproduce the models described by Fenwick above, suffocate opportunities for the dynamic ‘open world’ ontologies proposed by Tsoukas (2005). Tsoukas offers an ‘open world’ view where the chaos and complexity of postmodern concepts of learning are embraced and encouraged. In the context of midwifery education, the door to this world is ajar, but only just; the medical hierarchy and biomedical hegemony have ensured that existing frameworks (e.g. very detailed competency assessment documentation) prevail and are supported in an educational context (Cahill, 2001; Fullerton *et al.*, 2013). The novice who tries to craft their ‘own’ identity does so at their peril; personal experience of standing up to be counted, usually ended in sitting down to be chastised.

This landscape is, however, changing. Authoritative knowledge, pivotal to the maintenance of professional esotericism has been propagated out by the world wide web (Scanlon, 2011). Access to information (good and bad) has enabled consumers of services (women as students or women who are pregnant, sometimes both) to question the integrity and reliability of the organisational policies and processes that exist (Mander & Murphy-Lawless, 2013), but only a very small proportion do so. Thirty eight years ago, maternal health policy in the UK advocated choice, control and continuity of care for women, but only if it aligned with the choices and controls supported by the NHS. Students, like pregnant women are encouraged to embrace the choice, control and continuity of adult learning pedagogies, and yet are still likely to subscribe to the misconception that competence equates to knowledge (1415 competencies

worth of practice knowledge), although this demands a good grasp of what constitutes knowledge too. In respect of educational practices Ball (2013, p.13) proposes that ‘the production of knowledge is also a claim for power’ and that ‘these knowledges produce classes and categories of subjects, endowed with specific characteristics and requiring particular forms of intervention or practices’. This ‘knowledge’, which shapes the education of student midwives and the practitioners who emerge, arises from a combination of social, political and theoretical choices that this thesis aims to explore.

The process of ‘becoming’ then, is complicated and messy, Shutz cited by Scanlon (2011, p.14) posits that the initiate is not bound to worship ‘the idols of the tribe’, but it helps. Scanlon furthers this idea by adding that the initiate may not know who to worship, or the scale of worship that should take place. This can and has caused many difficulties for the student. Rarely does the initiate have the strength to counter the weight of power imbalances for a sustained period, and acquiescence usually takes place. The rituals that take place in organisations such as the NHS are integral to its sustained functioning (rightly or wrongly) and Foucauldian embodiments of power are embedded and visible throughout (Foucault, 1979). This is significant not only for the student who wants to join the club, but also for the women that they are caring for. Women who have, in extreme cases, been deemed to be mentally ill for calling the might of medicine into question (Mander & Murphy-Lawless, 2013).

Preparation of learners for practice presents further challenges; McIntosh *et al.* (2013) highlight the tensions between practice regulations and university philosophies. Hager, Lee and Reich (2012, p.8) attest to this and propose that

the ‘increasing dominance of formal education arrangements has tended to its (practice) being overlooked’, despite sustained articulation in the literature of its merits (Scanlon, 2011; Fenwick, Zukas and Kilminster, 2013). To date, the panacea for the perennial theory/practice gap in midwifery education has been constructivist pedagogies, such as evidence / enquiry / problem / case based learning strategies (Sidebotham, Jomeen and Gamble, 2014; Tully, 2010; Peace, 2012). Although questions arise as to how relevant application of a strategy such as this is for all learners; one study reports a student mentioning that they had not had any feedback for three years (Tully, 2010).

Caseload practice is another approach adopted by educationalists, but not always so happily by clinical practice (Fry, Rawnson and Lewis, 2008; Rawnson, Fry and Lewis, 2008). Here students are encouraged to manage care for their own client group of pregnant women, beginning to end, under the tutelage of a mentor (and a vast range of policies, guidelines and procedures). This represents the full spectrum of care that students will be expected to provide once they have become midwife, but in many areas this type of care is not reflected in working practices. Caseload practice is often abstracted from the academic environment and criticism of its efficacy is offered in the light of this (Rawnson *et al.*, 2009). If participation could be facilitated by education and practice, this might enable theory to be taught in, on and around practice, described by Fenwick as ‘on its travels dynamic knowledge’ (Fenwick, Nerland and Jensen, 2012). The economics of academic work practices and resources (including the will of the people involved) often obstruct the development of such initiatives, but it is here that there is hope for developing understandings of preparation of the ‘future’ (NMC, 2019) midwife. This discussion highlights the

need for a much more ecological approach to try to determine what is possible, but also practicable in midwifery practice education and is addressed in the findings of this thesis.

Conclusion

In this chapter I have highlighted the complexities inherent in conceptions of discourse, this with the intention of explicating a methodology appropriate to the aims of the thesis. Identities and their construction and performance also present challenges and require a research strategy which aligns with the perspectives taken for the analysis of discourse.

My exploration of the literature does not reveal previous empirical studies that have considered the discourses within which student midwives construct and perform their professional identities. Scant attention has been paid to the significance of discourse as a constitutive feature of the social practice of 'midwifery' in midwifery literatures. Furthermore, there is little evidence of empirical work which considers the significance that regulatory discourses have in respect of this. The discursive practices which shape the experiences student midwives have on programmes of professional learning are not articulated in the literature, where the empirical focus is broadly concerned with the collation of narrative 'experience' rather than the construction and performance of identity. There was no midwifery literature discovered which uses multi-perspectivism in the form of discourse analysis, positioning, small stories and micro-dramas that this thesis uses. The key conceptual threads that emerge from the literature regarding the construction of midwives' identities arise in the

discourses of autonomy, professional knowledge, professional leadership, education and clinical practice.

Chapter 3 - Methodology

Introduction

This chapter presents the methodological approaches taken in the thesis. I discuss the methodologies for the overarching research question as distinct sub-questions. Sub-question one is presented separately from sub-questions two, three and four as they apply different theoretical frameworks. Research question one uses the discourse analysis of Fairclough (1992) with the remaining questions drawing from the small stories of Bamberg and Georgakopoulou (2008), positioning of Davies and Harré (1990), and micro-dramas that I theorise as a new methodology and contribution to knowledge.

Methodology - research question one

Research question one is concerned with the ways in which midwives are constructed in the discourses of policy, learning and professionalism. It is useful to consider three aspects of this question, that of discourse, that of construction, and that of policy, learning and professionalism. Issues relating to discourse are approached first and form the basis of the following discussion.

An approach is required that can examine how midwives and their practices are understood in different texts or 'discourses' to construct new understandings for future practice. As Fairclough (1992, p.64) suggests 'Discourse is a practice not just of representing the world, but of signifying the world, constituting and constructing the world in meaning'. Research question one explores the

concepts and signs in the discourses of policy, learning and professionalism that lend meaning to the term ‘midwife’.

The discourses of policy, learning and professionalism arguably operate as Ball (1993, p.12) suggests, not tell you what to do but to create ‘circumstances in which the range of options available in deciding what to do are narrowed or changed’. Through this, questions of power and the production of ‘truth’ and ‘knowledge’ arise about which of these circumstances prevail. This gives us the parameters within which ‘midwives’ as subjects emerge. The perspectives that inform my methodology draw from the work of Fairclough (1992) and his perspectives in his seminal text ‘Discourse and Social Change’, because of his interest in how power, truth and knowledge are exercised in discursive constructions of selves. In this instance, that of ‘midwives’ and their construction in regulatory policy. Pivotal to this is the ‘order of discourse’ or the ‘network of social practices which constitutes the field’ (Fairclough *et al.*, 2009, p.165) that becomes the focus of analysis.

Concerning the ‘constructive effects’ of discourse, Fairclough (1992, p.64) proposes three: the construction of ‘social identities and subject positions for social subjects’, ‘social relationships between people’, and ‘systems of knowledge and belief’. He does this with the caveat that the constructivist effect of discourse should not be overstated. Fairclough (1992, p.61) argues that subjects are ‘not merely passively positioned but are capable of acting as agents, and amongst other things of negotiating their relationship with the multifarious types of discourse they are drawn into’. This plays out in the

‘constructions’ of midwives in question one within the SPRME, and how the participants construct themselves in questions two and three.

It is methodologically important to consider how policy is understood in the thesis. In a paper offering insight in respect of policy analysis, Ball (1993, p.10) cautions against taking the meaning of policy for granted in case ‘theoretical and epistemological dry rot’ is built into analytical structures. Policy as a unit of analysis is therefore approached using the definitions provided by Ball: policy as text and policy as discourse. As texts, Ball (1993, p.11) suggests that policies are ‘representations, encoded in complex ways and decoded in complex ways’. As discourses, Ball (1993, p.14) argues we are ‘spoken by policies, we take up positions constructed for us within policies’ but advises that this is difficult terrain. Instead, he suggests that ‘the complexity and scope of policy analysis – from an interest in the workings of the state to a concern with contexts of practice and the distributional outcomes of policy – preclude the possibility of successful single theory explanations’ (Ball 1993, p.10). From here, he proposes that the analyst utilise a conceptual and theoretical toolbox. I prefer to think of conceptual and theoretical multi-perspectivism as a thread that weaves rather than a tool that is housed in a box, and hope to demonstrate this in the approaches used to answer the remaining research questions.

Having undertaken a preliminary comparative discourse analysis of the General Teaching Council Standards for Registration (GTCS, 2012) and the SPRME (NMC, 2009) using the methodologies of Fairclough (2010) and Laclau and Mouffe (2015) I was able to gain an early appreciation of the challenges of this process. For the exercise, I used the ‘Foreword’ and one standard from each,

less than five hundred words in total. Such was the volume of data collected, that I had to re-evaluate my intention to analyse a range of policy documents and focus attention on one. As the regulatory text which definitively 'constructs' midwifery and midwives in the context of higher education, the SPRME were selected as the document for analysis.

I use the three-stage conception of critical discourse analysis [Figure 1] theorised by Fairclough (1992) which exemplifies the three 'constructive effects' of discourse previously mentioned. In relation to each of the stages, a sub-question which applies the framework to the SPRME and the research question was developed as follows:

At the level of the text:

What are the linguistic features of the text and what attributes would we expect midwives to have, given the way they are constructed in the text?

At the level of discursive practice:

How is the text produced and consumed and in what ways does the knowledge that emerges about midwives acquire authority as constitutive of 'the truth of the matter' in the texts?

At the level of social practice:

In what ways do these discursive practices reproduce or restructure knowledge and meanings of 'midwives' and 'midwifery' and how is this implicated in the construction and performance of student midwives' professional identities.

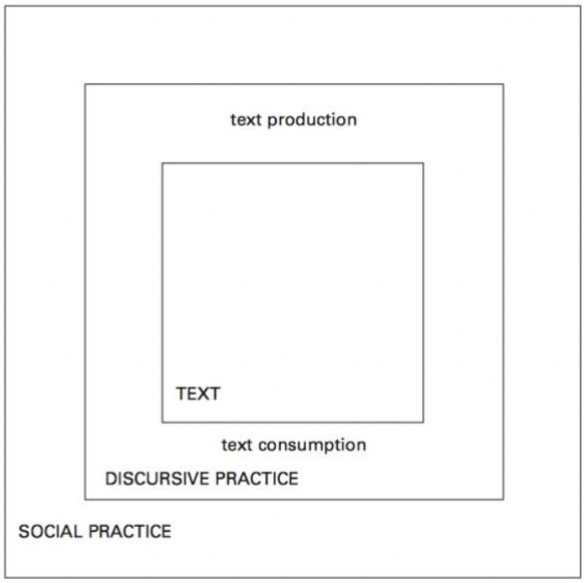


Figure 1 - Fairclough's three-dimensional conception of discourse

Each of the three stages is explored using guidance for analysis given by Fairclough (1992, pp.232-237). This is approached with his recommendation not to have too sharp a distinction between the boundaries of each of the three stages. This is despite the rather angular illustration of the concept that he presents.

Analysis of discourse at the level of the text

This aspect of analysis uses several conceptual threads to explore the text more closely in relation to what Fairclough describes as 'the ideational function of language' (1992, p.169). Interactional control is the mechanism by which authority is established, and is achieved through features such as turn-taking, exchanges and agenda-setting. Cohesion relates to how clauses and sentences come together to create the 'rhetorical mode' of the text. Ethos is described as the pulling together of 'the diverse features that go towards constructing selves' (ibid, p.235). Three dimensions of grammar: modality,

theme and transitivity, are also explored. Modality corresponds to 'ideational' function, explained as 'ways in which texts signify the world and its processes, entities and relations'; and transitivity to 'interpersonal' function which is understood as how social identities are 'set up in discourse' and 'how social relationships between discourse participants are enacted and negotiated' (Fairclough 1992, p.64) . In relation to modality, the verb 'must' will be the focus of attention. With transitivity, I consider the state of 'being' and 'having' represented through the various forms of the verb 'to be' and 'have'. The 'theme' is how recurrent patterns reinforce assumptions about issues, for example, the knowledge claims that are being made. Also considered is word meaning, where 'key words' and their significance are explored. In doing so, the 'wording' of phrases becomes relevant to theoretical, cultural and ideological constructions of subjects.

Analysis of discourse at the level of discursive practice

Fairclough, it seems, likes a list. First, discursive practice is understood to consist of 'interdiscourse' or the 'types of discourses that are drawn upon in the discourse sample under analysis, and how' (Fairclough 1992, p.232). Here 'interdiscursivity' is how 'elements' of 'orders of discourse' combine, or not, to constitute the discourse that prevails. This analysis draws from post-structural theoretical perspectives proposed by Laclau and Mouffe (1985;2015) and is a more covert mechanism to fix meaning at the level of discursive practice. Fairclough (1992, p.68) understands 'elements' as polysemic, in that their meaning is not fixed and that they have the potential for multiple meanings. These elements are part of an 'order of discourse' which according to

Jørgensen and Phillips (2002, p.56) denotes ‘two or more discourses, each of which strives to establish itself in the same domain’. Thus, “order of discourse” is also the term for a potential or actual area of discursive conflict’. For example, the sign ‘midwife’ and what is signified; perhaps ‘woman with woman’ or ‘nurse for delivering babies’ or ‘red-lipsticked figure from history on a bike with a basket who is in a hurry’ stand in relation to all those elements or signs that are not articulated e.g. ‘lay-person’, ‘man’ or ‘person not on a bike’. This creates the view that ‘unstable equilibria’ which are ‘constantly open to being re-drawn as orders of discourse are disarticulated and rearticulated in the course of hegemonic struggle’ (Fairclough 1992, p.124). The concept of hegemony becomes significant as the ‘theory of the decision taken in an undecidable terrain’ (Laclau and Mouffe 2015, p.xi). Therefore, the NMC’s interdiscursive construction of the subject position ‘midwife’ in the SPRME, hegemonic intervention and the conditions that relate to its articulation and disarticulation become a focus for analysis.

Second, ‘intertextual chains’ are the conditions within which ‘texts’ exist in a particular discourse sample and the type of ‘texts’ that emerge from this as a result. This aspect of analysis also considers the audience that the text producer anticipates the text will have and its ‘coherence’ or ‘interpretive implications’ as a document. From here, how the text is ‘consumed’ as a social practice is explored.

In Chapter 5 – Policy Analysis, I discuss intertextual and cohesive features of the SPRME as a text in the context of the practice of midwifery education. Third, also focusing on text production is ‘manifest intertextuality’ or ‘where

specific other texts are overtly drawn upon within a text; for example, the use of the discourses of the ICM and FIGO to configure the 'International Definition of the Midwife' in the SPRME. Here the concepts of 'genre' and 'style' become relevant, where the SPRME for example, is characterised as arising in the genre and style of policy. Fairclough (1992) also recommends considering issues of representation i.e the context, style or possible ideational meanings of the text and what he describes as 'presupposition'. This includes consideration of prior texts, perceived sincerity/manipulation and polemics or negative phrasing. Aspects of meta-discourse, for example the use of 'hedges' that afford the speaker a position as external to that of the text, and irony are also features that have analytic significance in respect of subject positions and discourse.

Analysis of discourse as a social practice

Social practice is exemplified using the 'social matrix of discourse' through the concepts of 'hegemony' and 'ideology' (Fairclough 1992, p.237). This part of the analysis aims to 'specify the social and hegemonic relations and structures which constitute the matrix of this particular instance of social and discursive practice' (ibid). There are two concepts at this level that help develop analysis in respect of how discourses give rise to meaning-making and the formation of midwives' identities, that of hegemony and that of interpellation. A brief description of both concepts is presented here, but both will be extended in the analysis. As Laclau and Mouffe (2015) interpret from Antonio Gramsci's theory, hegemony is how one discourse is undermined by another which overpowers it.

In the context of midwifery policy and practice, it is this concept and the context of the terrain that is of interest.

Interpellation is understood as how subjects come to be ‘hailed’ into the positions that they occupy through discourses (Althusser 2000). Although Althusser discusses interpellation in relation to ‘ideology’ rather than Laclau and Mouffe’s (2015) concept of ‘hegemony’, the principle that subjects and ideologies are co-constitutive in the interpellation of subject positions remains relevant to the analysis. As such, I consider the ways in which ‘midwives’ are produced, distributed and consumed as features of discourse and how this manifests at the level of social practice. I also explore the ‘systems of knowledge and belief’, ‘social relations’ and ‘social identities’ that this gives rise to. From here, Fairclough encourages consideration of how data collected through discourse analysis such as this can illuminate the findings of other empirical work. I illustrate the relationship of the data collected in this research question to that of questions two and three in the second part of this chapter.

Methodology for research questions two, three and four

Positioning and small stories

Research question two explores the ways in which student midwives position themselves in relation to the discourses of policy, professionalism and learning and is approached empirically. Holstein and Gubrium (2013, p.271) suggest that we ask the following when considering narrative work in practice: 'How can the process of constructing accounts be conceptualized?' and 'How can the empirical process be analyzed?'. For this study, the process of constructing accounts is conceptualised through the use of 'small stories' and 'micro-dramas' and the empirical elements are analysed using 'positioning' and the three-step process proposed by Bamberg (1997). Positioning is explained first as it creates the conditions for the explication of small stories and micro-dramas.

'Positioning' is offered by Davies and Harré as a contribution to the understanding of personhood, they describe the focus as being on:

> the way in which the discursive practices constitute the speakers and hearers in certain ways and yet at the same time is a resource through which speakers and hearers can negotiate new positions. A subject position is a possibility in known forms of talk; position is what is created in and through talk as the speakers and hearers take themselves up as persons. This way of thinking explains discontinuities in the production of self with reference to the fact of multiple and contradictory discursive practices and the interpretations of those practices that can be brought

> into being by speakers and hearers as they engage in conversations. (Davis and Harré, 1990, p.27).

Davis and Harré further define discourse as being ‘an institutionalised use of language and language-like sign systems’ (ibid, p.4) and like Fairclough (1992), propose that this takes place across varying levels and fields.

Providing as an example the positioning of adolescent girls, Davis and Harré (1990, p.6) argue that ‘the girls’ experience of gender, race, class, their personal-social identity, can only be expressed and understood as the categories available to them in discourse. They liken the concept of ‘discourse’ to that of the ‘conceptual scheme’ in contemporary scientific philosophy and state ‘it is that in terms of which phenomena are made determinate’. The difference between the two is that the former (discourse) is ‘a multi-faceted public process through which meanings are progressively and dynamically achieved’ and the latter (conceptual scheme) which is a ‘static repertoire’ located in the mind at the level of the individual (ibid). Various aspects of positioning are expounded as relevant to the production of ‘selves’ for example, speech acts - or what is said and how positions are instantiated through the process of conversation, indexicality - relating to how past experiences are drawn upon to arrive at a particular position, and typification - where a ‘culturally well-established cluster of attributes’ is called upon to recognise the position of the ‘self’ (Davies and Harré, 1990, p.12). These concepts are significant to ‘positioning theory’ and ‘small story analysis’ exemplified by Bamberg (1997), which moves ‘positioning’ into an analytic device relevant to the construction of identity.

As a methodology, positioning contributes to the understanding of personhood through the analysis of narrative accounts (Davies and Harré,1990). Positioning is defined as 'the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced storylines', this with the aim of developing understandings of 'how it is that people do being a person' (Davies & Harré, 1990, p.6). This description references the 'conversation' and 'storylines' as the site for analysis and as such warrants further discussion regarding how these conversations and storylines are to be conceptualised methodologically.

As aspects of talk these 'conversations' and 'storylines' are theorised as 'narratives'. In respect of what a narrative is, Watson (2012) reveals some of the tensions that relate to defining narratives in qualitative research, and progresses the discussion as to how they are implicated in the positioning of 'selves' and the construction of identity. A useful edict comes from Michael Bamberg (2005, p.231) who claims that for social scientists concerned with people's identities:

> the question of what narrative really is… is not relevant. I am working with what people tell us, but equally important, with how they tell their stories…… However, narratives are 'interesting' and 'telling' devices, since they usually enable speakers to arrange their claims in a more organized fashion.

Bamberg's methodological perspectives draw from ethnography, discourse analysis and socio-linguistics and are housed under the umbrella of social-constructionism (Bamberg 2005, p.221). Discursive approaches to narrative

analysis are proposed as a useful means of ‘paying close attention to the way speakers’ accounts are rhetorically and argumentatively organized’ (Bamberg 2005, p.221). These accounts are used not as much to determine form and content, but more to aid the analyst in determining their purpose with subject positions that are created as they arise. From here, how narratives are implicated in the construction and performance of identities can be explored, and the ontological frame that uses discourse analysis as the ‘thread that weaves’ is maintained.

Collecting narratives requires what Holstein and Gubrium (2013, p.271) describe as ‘narrative work’ or the ‘interactional activity through which narratives are constructed, communicated, sustained or reconfigured’. In the context of this study, the narrative work relates to the empirical data gathered through the recording of interviews with student midwives. Early reading led me to consider the significance of language in respect of not only my questions but also how the processes employed in my research would represent the ‘knowledge-claims’ (Allen, 2003, p.17) therein. Allen suggests that language, narrative and discourse are how we can express new understandings or ‘knowledge-claims’. I use a process for analysis that enables me to see the ways in which student midwives use language, narratives and discursive practices to construct and perform their social realities.

Extending the analytical frame, Bamberg and Georgakopoulou (2008), explore the use of story-telling and narratives as a mechanism for identity analysis about ‘big’ and ‘small’ stories. Described variously as ‘autobiographical’, ‘the canonical narrative’ and ‘big story research’ these accounts have often been

taken as what Bamberg and Georgakopoulou (2008, p.1) describe as ‘more or less unmediated and transparent representations of the participants’ subjectivities and from there as reflecting back on their identities’. Their point of departure from these broader narrative accounts is to argue for the worthiness of informal conversational narratives – ‘small stories’ and ‘how people actually use stories in every-day, mundane situations in order to create (and perpetuate) a sense of who they are’ (Bamberg & Georgakopoulou, 2008, p.2). Having listened to students reflecting on their experiences of becoming midwives both in the university and in clinical practice over many years, it was of interest to see how this might be further explored through the use of ‘small stories’.

Bamberg and Georgakopoulou (2008, p.3) conceptualise the small story as:

> a window into the micro-genetic processes of identities as ‘in the making’ or ‘coming into being’ forming the background against which identities in life-event or biographic interviews can become foci of investigations within the framework of more traditional narrative methodologies.

Bamberg (1997) proposes a three-level framework for positioning analysis. Positioning level one asks, ‘who are the characters in the story and how are they relationally positioned’, level two asks ‘why is it told this way?’ and level three asks ‘who am I in all this?’. Integral to this Bamberg and Georgakopoulou (2008, p.2) suggest the use of small stories as suitable sites for this identity work, with Bamberg *et al.* (2011, p.182) proposing the analysis of ‘small stories’ as a way of interpreting how ‘tellers index their sense of self in the here and now’. Positioning and its analysis is therefore used as a point of entry to the

analysis of the construction and performance of student midwives' professional identities.

This requires the collection of narratives in order that 'small stories' and 'micro-dramas' can be identified and used for analysis. Interviews with the students in the Simulation and Clinical Skills Centre (SCSC) using a range of midwifery equipment was the means by which this was employed (discussed in Chapter 4). Here student midwives were asked a series of questions related to the learning of a midwifery skill. One of the purposes of this Schostak (2005, p.10) suggests, is to 'open up the possibility of gaining an insight into the experiences, concerns, interests, beliefs, values, knowledge and ways of seeing, thinking and acting of the other'. In this space, he proposes that we come to view 'identities-in-action; or the performance of identities through the medium of the interview' (Schostak 2005, p.17).

I chose to use the SCSC as it is a space in which learning and teaching had taken place with the students. The 'tools' used to facilitate this discussion are seemingly benign: an abdominal model[2], a Pinard's stethoscope[3], a hand-held Doppler[4] device and some aquagel; but all are invested with particular meanings arising in particular discourses. For example, the Pinard's stethoscope has become emblematic of the discourses of 'craft' midwifery, while the Doppler is more closely aligned with the techno-scientific perspectives of bio-medicine (Blake, 2008; RCM/RCOG, 2017). These were selected with

[2] A truncated abdomen with a removable fetus doll used in simulation education
[3] 'A horn-shaped non-invasive device that is used by midwives to listen to fetal heart sounds' (Watson and McLuckie, 2020, p.386)
[4] 'an electronic device that uses ultrasound to convert movements of the fetal heart into sounds' (Watson and McLuckie, 2020, p.386) used with aquagel

this in mind. The rationale for the research setting and the equipment used is to explicate the interview questions by framing them with the seemingly 'everyday' background of the simulation centre. Similarly, the equipment used could also be perceived as an 'everyday' practice and, Schostak (2005, p.175) offers, open 'the way for the inter-view – as the 'place' of displacement – and the exploration of the pre-suppositionless pre-condition for any such ground to be either possible or impossible.' As such, they are useful as a means to explore differing discursive positions and how these are taken up or resisted in the construction and performance of identity.

Bamberg and Georgakopoulou (2008) propose that small stories serve many purposes: accounting for the past; the present; the future; and the imagined events that the teller may wish to include. They may also allude to previous discussions, omissions and denials and on a temporal level might unfold out of the immediate discussion without a prior form. My framework for analysis is developed from the five-step model described by Bamberg and Georgakopoulou (2008, p.1) presented below:

Step 1- Who are the characters and how are they relationally positioned?

(Positioning Level One)

Step 2 – The interactive accomplishment of 'narrating'. How the speaker/narrator positions herself (and is positioned) within the interactive situation.

(Positioning Level 2)

Step 3 - How is the speaker positioned within the interactive flow of turns that constitute the situation as research?

(Positioning Level 2)

Step 4 - The joint interactional engagement between participants.

(Positioning Level 2)

Step 5 – Who am I in all of this? How the speaker/narrator positions a sense of self / identity with regard to dominant discourses/master narratives.

(Positioning Level 3)

Here, they describe a three-level five-step process. In the framework for analysis that I used, I added my notations, excavated from the methodology that is somewhat covertly woven through Bamberg and Georgeakopoulos's 2008 paper. The following questions provide the analytical framework that was applied to linguistic aspects of the narrative data.

Positioning Level 1 - who are the characters and how are they relationally positioned?

- How characters are positioned within the story in space and time?
- Who is the teller and what is the story?
- What is there in terms of an event sequence?
- How are they constructed (e.g. as anonymous)?
- How are the midwives and the woman constructed?
- How are they characterised?

- At more general level what can the audience take into account in respect of characters?
- What is the taleworld? (events and characters or here and now of telling)
- Is there an animator role (does she enact 'others')?

Positioning Level 2 - the interactive accomplishment of 'narrating' - why is it told this way?

- How the speaker/narrator positions herself (and is positioned) within the interactive situation.
- What narrative elements are there? For example 'I remember once' - story constructed as relevant to the here and now of the present engagement – generic framing device sets up expectation and boosts tellability ('weird thing' etc).
- Do I wish to hear the story? What do I say?
- 3-part canonical structure – teller: story preface; recipient – request to hear story; teller – story.
- Alluding to potential – rhetorically foreshadowing content as relevant and reportable.
- Positioning as someone who has something to share – what are implications for me?
- Why is question framed as it is?
- What does enlisting a memory do?
- What does the animator do – what does it say?
- Does it allow student to navigate dangers of taking a stand on using materials e.g. the Pinard?
- Potential to implicate herself in involvement in particular discourse – does she?
- Does it shift issues of authorship – whose story is it?
- What do I do after story? What do I say?
- Speakers exploit different aspects of talk in order to mitigate, disarm or equally flaunt their accountability, that is, their normative responsibility for and commitment to what is being said and done.

- Do I offer encouragement to share in story?
- Does the storied response implicate student in any way – something that stories typically do.

Positioning Level 3 - who am I in all of this?

- How the speaker / narrator positions a sense of self / identity with regard to dominant discourses / master narratives.
- Position sense of self / identities vis-à-vis dominant discourses / master narratives.
- How to make identities relevant to interaction in here and now, and through all establish as a 'particular kind of person'.
- How does student position self from here?
- How is use of Pinard as described perceived in respect of discourses?
- Manoeuvring between which pulls?
- How are characterisations made?
- Does it pull towards midwifery or away?
- Who is the student – compliant / resistant?

These questions are asked of the data for each of the participants, with some aspects of analysis seeming to yield data that was more pertinent to the construction and performance of professional identities. Of particular note were the ways in which the Pinard and the Doppler became almost allegorical as aspects of the discourses within which the students constructed themselves. Significant to this insight and understanding was the process by which the data were transcribed using the transcription software. Slowing down the speed of the visual and audio data for transcription created interesting perspectives from which to interpret it. In doing so, the methodological research question emerged which asks *in what ways can gesture contribute to the development of small*

story analysis. I propose that the means to answer this lies my theorisation of 'micro-dramas'.

Micro-dramas

Having found a methodology to explore the narrative aspects of the data, it became clear during early analysis that there was also useful visual data to be collected in respect of gesture. I struggled to find an appropriate visual methodology with which to analyse the seen components of the data collected relative to the construction and performance of identity.

Rose (2014, p.25) defines visual methods as 'methods which use visual materials of some kind as part of the process of generating evidence to explore research questions'. Concerning as it does the discursive construction and performance of midwives' identities, my data collection in respect of gesture had to offer a way in which to analyse the 'performance'. The process of collecting the data required recording interviews of student midwives discussing the process of learning how to do abdominal palpation, a component of abdominal examination[5] frequently performed by midwives in the care of pregnant women. This component has semi-structured questions related to abdominal palpation, but in particular to two pieces of equipment used to listen to the fetal heart after this practice has been undertaken.

When transcribing the data of one of the first participants, something happened that caught my attention. As I listened to the narrative, I could see a fleeting

[5] 'During the antenatal period, abdominal examination is carried out to determine the symphysis fundal height and, from 36 weeks' gestation, to determine the presentation and lie of the fetus. To perform an abdominal examination, the midwife needs to be able to observe, palpate and auscultate the woman's abdomen' (Macdonald and Johnson, 2017, p.521)

gesture that seemed significant. As the student discussed the piece of equipment that she was holding, she very much kept it at ‘arm’s length’. This made me think that despite her having discussed where and when it had been used; she was not necessarily comfortable with it. This simultaneous, but contradictory performance through gesture that was being enacted, I have termed a ‘micro-drama’. It was important to see if my perception of significance was justified in the literature at this point, and as such, I read a great deal of theory without gaining much in the way of a methodological answer.

The significance of the micro-analysis of interaction has been variously described in the literature; Streeck (2008, 2013) presents it with content and context analysis, primarily in relation to communication and human interaction. Heath, Hindmarsh and Luff (2010) explore embodied interaction as an object for analysis, but there is little that describes how identities may be brought into view through this process. Proposing ‘words as gestures’, Janney (1999, p.953) in the field of linguistics, suggests that ‘pragmatic accounts of linguistic events remain emotively and motivationally opaque if the frame of reference provided by gestural uses of language is not included in the analysis’. Although Janney does not illustrate his theory relative to words and gestures with reference to any visual images, he does provide a useful definition of gesture. Understanding it as having two uses: ‘in a narrower sense, to refer to movements of parts of the body to express ideas’ and ‘in a broader, more figurative sense, to refer to characteristics of utterances intended to convey states of mind, attitudes, and intentions’ (Janney, 1999, p.955). Further, Janney (ibid, p.960,961) discusses different types of gesture: ‘iconic’ and indexical’ which produce ‘pictures of speakers’ states of mind, feelings, and intentions’;

‘metaphoric’ in which ‘analogous concepts’ are conceptualised and communicated; and ‘deixis’ where words are more commonly used to ‘function by analogy as gestures’ (e.g. the adverbs of place ‘here’ and there). Importantly, Janney (1999) also notes that when what is said is contradicted by what is ‘gesturally shown’, the ‘figurative gestural message almost always overrides the literal one in people’s interpretations of acts of speech’ (ibid, p.963).

The micro-drama that was illuminated by the recording occurred in a space that seemed beyond the scope of narrative interpretation, in that it could not be subsumed into the positioning analysis, but it was a ‘storied’ aspect of the data. It created what Rajchman (1988, p.95), presents in his paper: ‘Foucault’s Art of Seeing’, as a ‘*rupture d’évidence*’. In short, Rajchman articulates this rupture as the gap between the self-evident and the taken for granted, and what is actually going on. This concept of the r*upture d’évidence* seemed to articulate the juxtaposition between what was being said and what was being seen in the data and provided a hook upon which to hang some further methodological uncertainties and questions.

At this stage, I spent a considerable amount of time reading theoretical perspectives in and around visual research methods. In my struggle to find a suitable visual methodology, it seemed I was not alone, Pauwels (2010, p.545) in his reframing of visual research and the social sciences laments this ‘rather dispersed and ill-defined domain’, suggesting that it remained ‘sparse and limited in scope’. Literatures presented since this gap emerged have examined a multiplicity of perspectives: Rose (2016) offers an excellent overarching text,

which details various approaches and gives an extensive set of methodological questions that can be asked of the visual, but little of identities; Pink (2012, 2013) explores and describes various practices of seeing, but mainly through an ethnographic scope. All of which not only felt too 'big' to unfold the events that occurred in the micro-drama but also didn't feel like they would provide a method that would succinctly surface what is, according to Rajchman (1988, p.92) quoting Foucault 'invisible but not hidden'.

To narrow the field of methodological possibilities further, I looked at other ways in which researchers had analysed visual data. Hazel (2015) in a by-product of a larger project looking at visual and narrative interactions in their natural ecology in a university, presented conversation analysis (CA) as a methodology to interpret the processes under which research participants 'do' being observed on a moment-to-moment basis as part of the research process. Combining the narrative and visual in a similar way to my initial analysis, Hazel (2015, p.5) used the visual to explicate the narrative data, enabling the researcher to 'remain alert to both the sequential organization of the unfolding talk as well as the embodied features that co-constitute the interaction'. Hazel suggests that the methodology he uses offers a space for participants to perform identity work, but does not give an explanation or a discussion of how this happens. In the context of Foucault and the visual, Rajchman (1988, p.112) conceptualises the feeling of certainty about the need to explore uncertainty, as being 'where one sees something must be done without yet knowing what.' This was the feeling that I had at this point; when I looked at the images I knew what I could see, but I did not know methodologically what the best way to go about seeing it was.

Helpfully, Cassell and McNeill (1991, p.402) lend the study of linguistic perspectives to the field and propose that for the 'speaker and the listener, gestures help to build a representation of the narration, at all of its levels, and play an important part in the "telementation" [the transmission of ideas from one to another] of the story'. The key concept being that of 'representation'; Hall *et al.* (2013, p.1) state that representation is 'an essential part of the process by which meaning is produced and exchanged between members of a culture'. Systems of 'representation' in this context are informed by the theoretical assumptions of constructionism: that 'neither things in themselves nor the individual users of language can fix meaning in language. Things don't mean – we construct meaning using representational systems – concepts and signs' (Hall, Evans and Nixon, 2013, p.11). Therefore, if 'representation' is deployed as the central concept to 'gesture' and narration, gestural 'narratives' such as those suggested by Janney (1999) can be used to empirically investigate how midwives are discursively 'produced'.

At this point it also became clear that the methodologies that would be appropriate to my visual analysis would need to consider more than just what was being done in the image, but also 'modalities of seeing' (Rajchman, 1988, p.92). Described as '*properties of visual intelligence'* and relate to what is being seen, the contexts within which it exists and the spaces that it occupies. It is here that Rajchman (1988, p.103) suggests that the 'subject' is given; these visual spaces, he suggests, help 'to determine who and what we think we are'. Here I felt able to identify a way to patch together some aspects of the collated elements of visual analysis and my micro-dramas to that of Bamberg and Georgeakopoulos's (2008) positioning analysis. Rajchman (1988) goes on to

theorise how the visual can be explored with Foucault's 'Art of Seeing', I felt this could be developed into a set of questions that could be asked of the data. Initially twenty-eight were collated, which were distilled into ten and then six.

The questions that were considered in respect of my visual analysis are presented below; the questions were integrated as appropriate with the steps of positioning.

1. What can be seen in the image and why?
2. In what ways does this image present a *rupture d'évidence*?
3. What do these gaps do to illuminate what is unthought about the image?
4. What is normalised in the image?
5. How is the participant constructed by the space and the objects within it?
6. What can be problematised by the image?

While these were the distilled questions, the version below shows my extended version with additional commentary, used as an aide memoir during the process of analysis.

1. What can be seen in the image and why? (consider also the social identities of the maker the owner and the subject / what are the relations between the maker the owner and the subject / is it one of a series / what has technology done to the image and why / what do the different components of the image signify / what are the material elements)

2. In what ways does this image present a rupture d'évidence? (What gaps exist between the self-evident / taken for granted and what was actually going on? Does the image reconstitute those identities and relations?)

3. What do these gaps do to illuminate what is unthought about the image?

4. What is normalized in the image? (What is its material form/what materialities exist?)

5. How is the participant constructed by the space? (How is the participant able to be in the space? What is the participant doing in the space, what gestures are made? What interactions take place and with what? What knowledges are being deployed / whose knowledges are excluded from this representation /does this images' particular look at its subject disempower its subject?)

6. What can be problematized by the image? (How does the participant occupy the space? Is the image one of a series and how do the preceding and subsequent images affect its meanings / is more than one interpretation of the image possible / have the technologies used to display it affected the audience's interpretations of this image / does the audience matter / how do these axes of social identity structure different interpretations?)

At this stage, I had a process for analysing the narrative elements of the data and a process for analysing the visual elements of the data, but what I did not have was a suitable means with which to represent the data. Bamberg and Georgakopoulou (2008) use elements of socio-linguistics in the transcription process of their analysis, but do not present a detailed discussion as to why. If discursive practices extend beyond the written word and can be understood as 'all the ways in which people actively produce social and psychological realities' (Davis and Harré, 1990, p.4) justification is provided for the extension of

positioning analysis through the use of both verbal and visual methods. This necessitates a robust process of transcription as part of the analytical frame, described below.

Transcription

Transcribing data requires careful consideration of the 'analytic, social and political meanings' that 'entextualization and recontextualization' (Bucholtz 2007, p.802) can give rise to. This requires the researcher to consider not only the methodological implications of transcription, but also the significance of what is given form and represented on the page. Transcription is not a written substitute for what has been recorded but is a process that selects 'theory laden renderings of certain aspects… produced with a particular purpose in mind' (ten Have, 2011, p.4).

Consensus emerges from the literature regarding the importance of using appropriate theoretical perspectives to underpin transcription practices (Edwards, 2005; Heath, Hindmarsh and Luff, 2010; ten Have, 2011) and in doing so present a consistent approach to the process. For the purposes of transcription I use 'sociocultural linguistic' perspectives proposed by Bucholtz (2007). Understood as 'the broad interdisciplinary field concerned with the intersection of language, culture and society', sociocultural linguistics affords the researcher a 'shorthand device' to a range of theoretical viewpoints from which to inform transcription (Bucholtz and Hall 2005, p.586). This overarching framework is informed by sociolinguistics,[6] conversation analysis, critical

[6] Bucholtz and Hall (2005, p.608) discuss that the term 'sociolinguistics' has a similar range of reference, to '*sociocultural* linguistics' but has a narrower reference for many scholars and is

discourse analysis, linguistic anthropology and social psychology among ‘others’ (Bucholtz and Hall, 2005). In a useful paper discussing the salience of transcription as a political imperative in the research process, Bucholtz (2000, p.1439) suggests that interpretive (what is transcribed) and representational (how it is transcribed) decisions must be made explicit. Therefore, for this research, the sociocultural linguistic methods for transcription described by Bucholtz (2000,2007) are used. Integral to this are the ways in which sociocultural linguistics provides resources for identity as the process of transcription takes place. Bucholtz and Hall (2005, p.585) suggest that in the relationship between the ‘self and other’ factors such as ‘similarity/difference, genuineness/artifice and authority/delegitimacy’ are significant.

The transcribed data of the small stories relates to video-recorded interviews rather than naturally occurring conversations. I use a software package called F5 that enables me to slow down the narrative and watch the recording at the same time. At first, the process of transcription involved watching and listening to the recordings for general meaning, and to structure, notice and identify aspects of interest. Gumperz and Berenz (1993, p.4) describe this as ‘the segmentation of the interaction into thematically coherent and empirically boundable portions, that is, “events” within the encounter as a whole.’ In this instance, the ‘events’ are the ‘small stories’ in the transcripts. Following this, a rough transcript is made for each participant recording the whole interaction.

The small stories are more concerned with content than structure therefore there is less requirement for the notation that elaborates features such as

therefore ‘encumbered with a particular history of use’.

prosody, pronunciation and dialect. Bucholtz (2007, p.788) suggests that 'sometimes a simplified transcript can make a point more concisely and clearly than a detailed transcript' but in the avoidance of oversimplification, adds that an acknowledgement of any omitted text should be made as a bare minimum. The process of decluttering the text to make it more readable is something which 'researchers have repeatedly shown…..cannot be determined in advance' (Bucholtz 2007, p.795). Therefore, an iterative approach to the process of transcription was required, as I did not initially know what was analytically significant and how this should be represented on the page.

The transcription is structured using vertical structuring and line numbers for ease of reference in the analysis. There is much discussion in the literature on how to structure data sequences, Edwards (2005) provides a useful example of the analytic implications to the perceived dominance of speakers and columnar and vertical presentation. As I am more interested in the small stories of the participants and less interested in dominance in interactions between interviewer and interviewee, vertical structuring is used.

Data Example 1

CM: ok so I have one, two, three, four, five, six questions

P5: /ok\

CM: /that\ I will ask you and the first one is

can you remember experiencing this=

doing this for the first time?

Luff and Heath (2015, p.367) propose that ‘different methodological commitments place very different demands on not only what is examined and transcribed but also on how the transcription is structured and laid out. They remind the analyst that simple choices influence how and what the reader notices from the transcription and all these decisions have impact on the presentation and interpretation of the analysis. In respect of formatting, I have chosen to use ‘informational phrases’ (Gumperz and Berenz 1993) or ‘units of meaning’ (Copland *et al.*, 2015, p.193) as the means to represent the speaker on the page. I use one or two informational phrases on each line with the line ending at the end of a phrase, this is to follow the rhythm of the speaker and help keep the transcript readable.

In avoidance of some of the pitfalls of modified orthography, such as ambiguity and condescension (see Edwards 2005, p.8 online for useful insights as regards this) standard English is used throughout. I have also included filler words such as ‘em’ and ‘uhuh’ as these often precede comments that are significant to the analysis. Contractions are frequently used and are presented using standard orthography. Following close examination of the text, the following transcription notations from Holmes, Shnurr and Marra (2007, p.448) were found to be analytically appropriate. I have added an exclamation mark (!), representative of an exclamatory utterance, a notation for a longer pause (++) and an equal sign (=) to indicate latched utterances, to the list. These are therefore the conventions used to explicate representation of the verbal conduct of the participants in the transcript:

<u>yes</u>	Underlining indicates emphatic stress

[laughs]::	Paralinguistic features and other information in square brackets, colons indicate start/finish
+	Pause of up to one second
++	Longer pause
=	Latched utterance
... /.....\...	Simultaneous speech
... /.....\...	
(hello)	Transcriber's best guess at an unclear utterance
?	Rising or question intonation
!	Exclamatory utterance
-	Incomplete or cut off utterance
. . . [. . .]	Section of transcript omitted

Edwards (2005, p.1) highlights the importance of iteration in the transcription process and encourages the researcher to 'listen to recordings repeatedly throughout the course of a study and to update the transcript to reflect developing insights.' Again, standard orthography is used, as it is the story that is of interest rather than the pronunciation or dialect of the speaker. Pauses are recorded using the notation described above and will only be used in the transcription when they are felt to be significant to the analysis. Prosodic features of the text such as rising intonation and emphasis are recorded using simple (see Data Example 2 below) transcription notation. Latching and overlap are features of discourse analysis more concerned with turn-taking in the

analysis of conversation (Jefferson, 1989; Gumperz and Berenz, 1993; Edwards, 2005) and are featured in the transcript where relevant. There are differences in how variation in transcription systems present overlap and latching, Data Example 1 (above) indicates how I have approached this.

Data Example 2

P5: well it was before we'd gone out on practice

so as with all the practical skills it was <u>terrifying</u>

While it is suggested that transcription should address *how* things are said as well as *what* is said (ten Have 2011), I would add that the visual methodology employed would also address *what is done* as it is being said. This is achieved with visual images in the transcript. These are digital stills that have been anonymised using an application that changes the photograph into a black and white pencil sketch. These are inserted where analytically relevant in the transcript and enable the images to be presented in the page as they occur with the text. The images that are integral to the analysis are inserted contemporaneously with the section of transcript that they relate to and help to 'map' the talk, visual conduct and 'particular details of material conduct' that are appropriate (Luff and Heath 2015, p.381). Each image will have a short description alongside to illustrate what is happening as in data example 3 below.

Data Example 3

CM: and do you feel comfortable about using that?

[CM points to pinard]

Figure 2 - pats Doppler

P2: [glances at pinard]

not as as comfortable as I feel using this+ [pats Doppler]

Bucholtz (2000 p.1439) reminds that ‘a reflexive transcription practice, as part of a reflexive discourse analysis, requires awareness and acknowledgement of the limitations of one’s own transcriptional choices’. For the small stories in this study, the transcription methodologies presented above are considered no less significant than those methodologies used elsewhere in the analysis. Rather than leaning towards the scholarly preoccupation with reliability and validity in transcription processes, this analysis moves towards acknowledging the role that interpretive and representational processes have in informing and

elaborating understandings of discourse and its analysis in new and meaningful ways.

Developing the analysis of the visual transcript - methodologies for answering research question four

In respect of research question four, I use three different examples of gestural data and the 'micro-drama' with positioning analysis and small story work. All of which contribute to answering the research questions.

Having analysed participant one as the basis for theorisation, it could be seen from the volume of data collected that it would be impracticable to present fifteen similar pieces of analysis. Mainly because it would be time-consuming and difficult to read. As the purposeful nature of the micro-detail emerged it became important to give due regard to this in the transcription process, particularly about answering my methodological research question. The stultifying effect of too many words in the verbal transcript made it difficult to see what was happening in the visual and make connections between the participants. I use 'frames' as a methodological shortcut to illustrate the key verbal and visual data relative to the small stories and micro-dramas. Presenting data in this format is challenging in that it requires the analyst to select those 'frames' which best support the analysis. It was important not to lose the connection between the verbal and the visual so not all of the transcript section was storyboarded, as there was a risk that over-refinement would lead to the meaning being lost. In Chapter 7, I present four examples of the use of the 'micro-drama' as an extension of the analytic framework applied in respect of positioning and small stories. This is provided as a justification for the

significance of gesture as a feature of the construction and performance of identities when doing 'identity work'.

Conclusion

This chapter has provided the methodological means by which the research questions are approached. It discusses Fairclough's (1992) framework for the analysis of the Standards for pre-registration midwifery education NMC, 2009). It provides the process by which positioning is used to analyse the narrative data in the small stories using Bamberg and Georgakopoulou's (2008) three levels. It also explains the micro-drama and how this data can be combined with that of small stories to provide additional insight into the construction and performance of identity. This process will be employed in the research design presented in Chapter 4.

Chapter 4 - Research Design

Introduction

This chapter discusses the design of the research and presents a justification for the methods used to answer the research questions. It describes how social constructionist approaches to research informed the development of the thesis. It details the methods applied to the sub-questions and also presents how the questions are mutually implicated in answering the overarching research question. I approached the development of the research questions using what Holstein and Gubrium articulate as a 'mosaic' (2013, p.253) of theoretical and methodological tools, suggested as a mechanism for countering the difficulties of dealing with such a wide-ranging paradigmatic approach. My research methods include document collection, interviews and observation, each of which yields data with differing analytical considerations. I discuss the ethical issues that relate to the study and the collection, storage and risks involved in this.

To answer research question one, elements of Fairclough's Critical Discourse Analysis (CDA) (1992) presented in Chapter 3 are used to analyse the professional and educational policy context. Questions two and three are set out in Chapter 3, and use Bamberg and Georgakopoulou's (2008) development of Davis and Harré's (1990) concept of 'positioning' and narrative in the form of 'small stories' as methods for data collection and analysis. In respect of the visual aspects of the data, a lack of any appropriate methodologies required the development and application of a new perspective which I have termed 'micro-

dramas' (discussed in Chapter 3). Here, the role of gesture is used to enhance insight and understanding of the performance of identity as it is co-constructed through narrative work.

Philosophical Assumptions

The research questions are concerned with discursive practices and the construction and performance of identities; therefore, my research design employs methods that serve this purpose. Denzin and Lincoln (2013) assert that qualitative research strategies are found at the intersection of the biographical, historical, cultural and political moments that give meaning to people's lives, therefore an exploration of qualitative methods seemed to offer an appropriate point of entry for my research design.

Early reading in and around qualitative methods led me to towards theories of social-constructionism, proposed by Holstein and Gubrium (2013, p.253) as a means in which we can understand how 'everyday realities are actively constructed in and through forms of social action'. This ontological perspective eschews the positivist notion there is an objective truth that can be measured and studied. Instead, it considers that multiple realities exist and that are constructed and co-constructed by individuals and the contexts within which they live. In developing an understanding of these realities informed by constructionism, it is suggested by Guba (1990, p.27) that the researcher has a subjectivist epistemological orientation, in that 'the inquirer and the inquired into are fused into a single entity. Findings are literally the creation of the process of interaction between the two.' With regard to the transferability and generalisability of this research, the aim is not to produce 'generalisable'

findings about midwife professional identity, but instead to illuminate the means, practices and resources by and through which student midwives construct their professional identities in order to point out 'what kinds of assumptions, what kinds of familiar, unchallenged and unconsidered modes of thought the practices that we accept rest' (Foucault, 1988, p.154).

The methodology, i.e. the processes utilised to reveal new knowledge, needs to be in alignment with constructionist thinking around discourses and how selves and subjectivities come into being. If social constructionism is an umbrella within which my study is housed, then 'discourse' and 'discourse analysis' are the rib and stretchers that can be used to open it up for analysis.

The overarching research question asks:

What are the discourses within which student midwives' professional identities are constructed and performed and what significance does this have for professional learning and practice?

Addressing the sub-questions through the research design

Question 1

How are student midwives constructed in the discourses of policy, professionalism and learning?

Research question one is concerned with the ways in which midwives are represented in the 'discourses' of policy, learning and professionalism. It is useful to consider three aspects of this question: that of discourse; that of construction; and that of policy, learning and professionalism. Discourse as a

concept has regularly and variously been described (Foucault, 1972; Wodak and Meyer, 2009; Fairclough, 2010; Laclau and Mouffe, 2015). Fairclough (1992, p.3) suggests it is widely used in social theory and analysis to 'refer to different ways of structuring areas of knowledge and social practice'. In this study, it is the knowledge that structures the social practice of 'student midwives' and 'midwifery' that is of interest. As such, question one uses Fairclough's (1992, p.73) three-stage conception of critical discourse analysis explained in Chapter 3.

The discourses that inform the policy context and governance of midwifery education are seen mainly in the Nursing and Midwifery Council's 'Standards for Pre-registration Midwifery Education [SPRME] (NMC 2009), 'The Code: Professional standards of practice and behaviour for nurses and midwives' (NMC 2018), and 'Practising as a Midwife in the UK (NMC 2017). While all of these documents were initially considered as 'texts' for analysis, it became clear early on in the thesis that the SPRME were the most significant. The SPRME definitively detail the ways in which the NMC articulate what 'midwives' and 'midwifery' are. While these standards are open to interpretation by the different stakeholders involved, regulatory sign-off as regards AEI programmes of preparation is mediated and enforced by the NMC. The SPRME are the primary discourse within which 'midwives' in the UK are constructed; for this reason they are the primary focus of the policy analysis.

Question 2 & 3

How do student midwives position themselves in relation to these discourses?

In what ways are these positions implicated in the construction and performance of identities and what significance does this have for practice?

Research question two narrows the focus of analysis and asks how student midwives position themselves in relation to the discourses of policy, professionalism and learning. From here, question three asks how these positions are implicated in the construction and performance of their identities and the significance this has for practice. Despite being discrete questions, they are intertwined and are separated for analytic purposes only. To this end, both will be approached using Davis and Harrés' (1990) concept of 'positioning' and Bamberg and Georgakopoulou's (2008) 'small stories' explained in Chapter 3.

The questions asked of the participants were designed to draw out the 'small story' data discussed above. It is the 'seemingly uninteresting titbits' that Bamberg and Georgakopoulou (2008, p.5) describe that in this instance give rise to 'discourse engagements that engender specific social moments and integrally connect with what gets done on particular occasions and in particular settings'. I wanted to elicit the students' recollections of learning a particular midwifery skill in order to encourage them to narrate and therefore position themselves in relation to these experiences. I asked the following questions of each participant with this in mind.

Can you remember learning about abdominal palpation for the first time?

How did you feel about it then?

How does it feel seeing it now?

Do you use these things?

Do you think it was a useful thing to do?

Do you feel different now?

It is acknowledged (Schostak, 2005) that to divide thinking up on the page is to make the research questions seem like discrete chunks of work. To counter this, Ozga (1990, p.359) suggests that it is important to 'bring together structural, macro-level analysis of education systems and education policies and micro-level investigation, especially that which takes account of people's perception and experiences'. This understanding and intertwining of macro-level and micro-level analysis as a methodological approach is helpful, but in the light of this, it is important to have an ontological perspective that enables this. Research questions two and three extend the broader discourse analysis of research question one, with the site of entry for analysis through the 'micro-level' investigation suggested by Ozga, theorised by Davies and Harré (1990) and implemented by Bamberg (1997).

Research setting

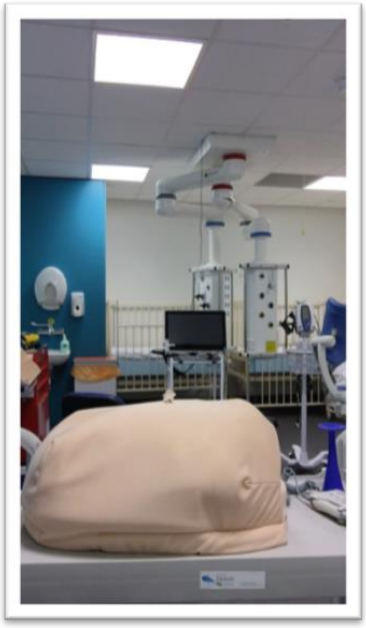


Figure 3 - The Simulation and Clinical Skills Centre

The interviews took place in a part of the university known as the ‘Simulation and Clinical Skills Centre’ (SCSC). This environment is where learning and teaching associated with practical midwifery ‘skills’ is undertaken and is deemed by the University to be state-of-the-art in its design. For the interviews, I used a room (Figure 3) used to teach small groups of students that also houses various pieces of clinical equipment. I added the trolley with the abdominal model, ‘Pinard’s stethoscope’, ‘hand-held Doppler’ device and Aquagel as part of my research design (the rationale for which is discussed in more detail later in this chapter). While some students may not have been in this room in particular, they had all been in the SCSC for aspects of learning and teaching by the time the interviews took place. Ordinarily, students and lecturing staff are required to wear a ‘uniform’ whilst in this environment. Although some of the students did ask if they should do this, I did not feel this

was necessary. Such is the power of ‘uniform’ I felt it would change my position as ‘researcher’ to that of ‘lecturer’ as I have a ‘higher status’ uniform.

Included is a photograph of the room (Figure 1) used for the interviews, the contents of which were the same for each participant. On one occasion, there was a requirement to use a different room with a participant (P10), but the research tools remained the same. Several of the participants refer to ‘Noelle’ or ‘the big dolly’ in their transcripts, I have included a photograph of the simulation model in a ‘delivery bed’ as a point of reference (Figure 4), the Pinard and the Doppler can be seen in the foreground. The three pictures that follow this depict the abdominal model, the Pinard stethoscope and ‘auscultation’, and again are provided as a point of reference (Figures 5).

For convenience, I arranged to meet each participant at a time when they were already timetabled to be in the University for teaching.

Figure 4 - the big dolly

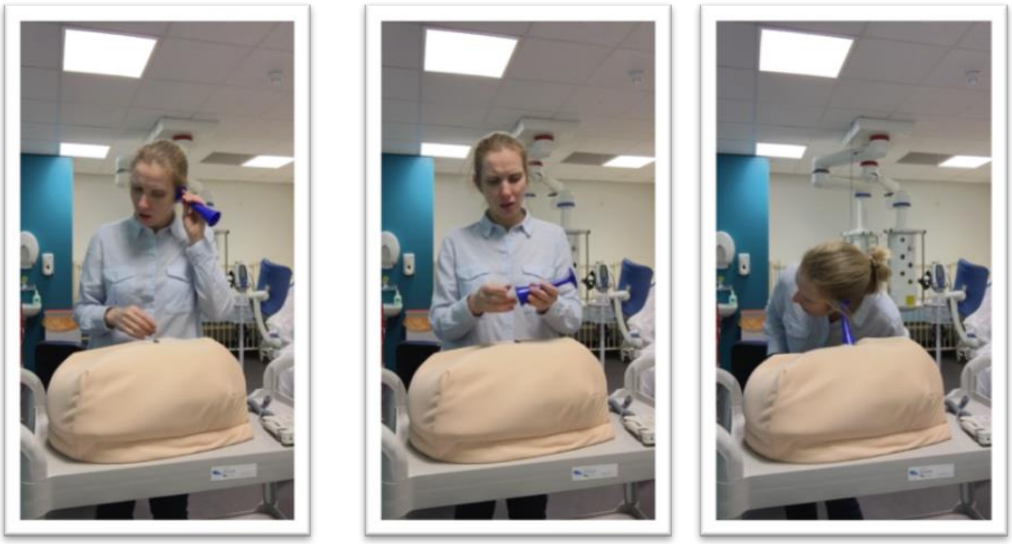


Figure 5 - the author, the abdominal model, the Pinard and 'auscultation'

Data collection

The students were recorded using the camera function on an iPad. This technology has the advantage of being relatively simple to use and does not require sound recording equipment as an additional feature. As I am familiar with using an iPad, this mitigated some of the implications and pitfalls of using over-complex technologies. I also assumed that the participants would be more comfortable being recorded on an iPad as mobile technologies are more commonly used in everyday life. An email from a student contacting me regarding participation in 2014 indicates how my assumptions were received - *Ugh, Connie..... Why are you filming for your PhD. Filming...!!!!!!!! I can do it. But....FILMING!!!!!'*.

I had originally anticipated recording the students in small groups of two or three, but I have written in my research diary *re: original plans to record in pairs or 3's – students feel too vulnerable to do this - naive on my part.* I had to alter my research design to accommodate this and moved from the recording of

learning and teaching as it took place in the classroom to a more structured interview using a series of questions and prompts. This included video-recording interviews of student midwives discussing the process of learning a clinical skill. In this instance, the skill of ‘abdominal examination’ forms the basis for the discussion. This is a technique frequently and routinely performed by midwives in the care of pregnant women. It is described in a commonly used midwifery text as:

> during the antenatal period, abdominal examination is carried out to determine the symphysis fundal height and, from 36 weeks’ gestation, to determine the presentation and lie of the fetus. To perform an abdominal examination, the midwife needs to be able to observe, palpate and auscultate the woman’s abdomen (Macdonald and Johnson, 2017, p.521).

Semi-structured questions related to abdominal examination were asked, particularly relating to two pieces of equipment used to listen trans-abdominally to the fetal heart after this practice has been undertaken. I chose these pieces of equipment as I propose they offer material representations of differing midwifery discourses; the Pinard’s stethoscope as emblematic of ‘craft’ midwifery discourses, and the Doppler as arising in the techno-scientific discourses of bio-medicine. The Royal College of Midwives (RCM, 2012, p.5) discuss these devices as follows:

> Fetal heart sounds can be heard using a fetal or Pinard stethoscope or a hand held Doppler device. The Pinard stethoscope allows the clinician to hear the actual heart sounds. Auscultation with the hand-held Doppler

> uses ultrasound to detect motion of the fetal heart valves or walls and converts this information into a sound that is heard or displayed as a representation of the fetal cardiac cycle. There continues to be debate concerning the use of the Pinard stethoscope within today's modern practice and it would appear that its use is a dying skill despite the fact that it is specifically included within the standards for pre-registration midwifery education (NMC 2009b, p.44). Discussion published by the Association of Radical Midwives demonstrates that some midwives firmly believe that the Pinard is a tool that is vital in the assessment of fetal wellbeing despite the fact that it can be difficult to use depending upon the position of the mother and that it does not give the mother the reassurance that is gained from hearing the heart beat (ARM 2000). It is also recognised that as the Doppler converts movement of the heart into sound there is potential for this to be inaccurate and misinterpreted. It is currently recommended that the Pinard stethoscope should be used in the first instance to determine that there is a fetal heart before applying a CTG or when any concern arises (MHRA 2010).

Using this equipment allowed me to record the student midwives doing something with 'taken-for-granted' midwifery related discursive practices and materials while responding to midwifery related questions. Initially 'doing something' was to gather small stories through the narrative aspects of the data collected. It quickly became apparent that the 'doing something' i.e. the emergent gestures, were significant performative aspects of identities in the making. As Cassell and McNeill (1991, p.376) explain 'In many ways, gestures add another dimension to the narrative - certain aspects of events may only be

conveyed in gesture and not in speech, or vice versa or different aspects may be conveyed in each medium giving us a more complete view of the speaker's conception of the event'. This gave rise to the methodological question posed as question four *In what ways can the inclusion of gesture contribute to the development of small story analysis?*

Research participants

Sixteen participants were recruited across three years of the Bachelor of Midwifery Programme at Edinburgh Napier University. As I was the programme leader at this time, I was aware that this position could deter students from choosing to participate. I therefore initially contacted the cohorts through my University of Stirling email account to try to differentiate my roles. This had no impact, as there were no responses in the first week. I had to reconsider my recruitment strategy and was able to contact the students again through the Edinburgh Napier Student Association class representatives using a research flyer. This resulted in a trickle of students coming forward. All of whom highlighted the issue that while video recording learning a clinical skill seemed straightforward to me, it was challenging and scary for them.

Difficulties with recruitment to the study required me to respond to the students' concerns that they did not want to be filmed demonstrating/learning the skill. Because of this, I had to change some of the processes for data collection and use the models and equipment as 'prompts' to stimulate discussion for the narrative data. This enabled me to recruit sixteen students across the three years of the programme. Due to the timing of student theory and practice blocks, (students expressed a preference not to have to come in when on a

clinical practice experience), filming began when the cohorts were in the University for theory modules.

One student came to see me before being interviewed and was extremely distressed, as my research flyer had prompted her to think about whether she still wanted to become a midwife. This unsettled my own taken for granted assumptions regarding the research process and raised issues regarding vulnerability and trust. It also became clear that the third-year cohort was suffering from a degree of 'research fatigue' having already been asked to participate in six other research studies. When potential participants came forwards, I was able to give them information and answer any questions regarding the study following their reading of the flyer.

Access to data and ethical considerations

BERA (2018) underpin the ethical guidelines for educational research regarding an 'ethic of respect', considering the person, knowledge, democratic values, quality and academic freedom. All of which provide a paradigm within which to protect all of those involved in the research process. This project raises practical issues about my position as the programme leader, and power and knowledge differentials in the research process. As has previously been discussed, 'identity is the social positioning of the self and other' (Bucholtz & Hall, p.586), undoubtedly the process will shift the learning experiences of the participants, and intervention of any sort will influence this 'shift' and possible perceptions of 'self and other'. The fact that participants would be undertaking the skills activities as part of their existing programme alleviates this to a degree; however, they would not be involved in interviews. In respect of this,

participants were given accurate information of what was involved, and how the data would be used, before consenting to participate.

In trying to counter these challenges, and in trying to work ethically, a self-criticism is required that situates the self in the context of history (Foucault, 1994), revealing questions as to the relational aspects of 'being' as a researcher. Schostak (2005, p.135) describes the researcher as 'a witness to the ways in which different individuals and groups give witness to their experiences and views' he also cautions that 'we all make judgments all the time'. These matters are significant in that they are not just a research procedure; they have the potential to influence the social and cultural world that the participants occupy. The distressed student who had cause to question her identity as a student midwife on account of my research flyer is a clear example of this.

Data collected from participants were anonymised through the use of pseudonyms and safely stored in a locked filing cabinet. As this research process has been carried out at Edinburgh Napier University (ENU) with student midwives and lecturers, it required ENU ethical approval. As no contact is being made with service users, NHS ethical approval is not required.

Consent and potential risks

As the programme leader, I had an authoritative position on the Bachelor of Midwifery programme in respect of the student midwives. Following a discussion of the process, all participants were asked to sign a consent form that summarised the proposed research, the nature of the collection of video

and audio data, and their right to withdraw consent at any stage in the research process. Clear information was given that the research was not in any way related to performance on the programme and that data collected would not be used to inform anything other than its proposed aims. The right to withdraw was reinforced throughout the data collection period. Verbal agreement was sought at the beginning of each video and audio session. It was not anticipated that it would happen, but any participants who expressed distress or anxiety would be referred to support services within Edinburgh Napier University (such as the pastoral care advisor or counselling services). When it did happen, this is the process that was followed.

Data Storage

Electronic files are to be stored for the lifetime of the project on a password-protected personal computer. Files are coded to ensure anonymity. Care and attention have been given to the use and safe storage of portable electronic devices, such as laptops and memory drives. A reflexive awareness of the ethical implications of conducting research is part of the process of this doctoral study.

Transcribing the data

For the small story analysis the interpretive aspects of transcription are framed using ‘sociocultural linguistic’ perspectives explained in Chapter 3. These approaches are redolent of those employed by Bamberg (1997) and Bamberg and Georgakopoulou (2008) in their small story analysis and were felt to be a good fit with the interpretive elements of the analysis. With such a range of

perspectives the imperative is on the researcher to select relevant methodological threads with which to tie the process of transcription together. The purpose of which is not only to explicate the analytic implications of the transcription conventions used but also to account for how these conventions seek to represent the discourses of the participants in the study.

As this study incorporates both verbal and visual data, here 'sociocultural linguistic' approaches as regards representation include nonverbal aspects of transcription such as gesture and gaze. Referred to in the literature as 'multimodal' transcription (Bezemer and Mavers, 2011; Streeck, Goodwin and LeBaron, 2011; Luff and Heath, 2015, p.386) this additional process combines auditory, visual, material and textual perspectives as an appropriate means to support 'the analysis of details of visible conduct that hitherto were inaccessible to inquiry, providing the foundation for assessing a range of novel substantive and analytic concerns'. From here, I incorporate 'multimodal' transcription into the umbrella term of 'sociocultural linguistic' transcription.

Transcription takes a 'fairly conventional written form' (Watson, 2007, p.375) acknowledging that the process involves translation from the original form and is therefore inherently subjective. I was responsible for the transcription of all the data as I aimed to add a layer of authenticity to its translation.

Conclusion

In conclusion, this chapter described the rationale for the design of the thesis. I have discussed how the philosophical perspectives explained in the methodology are employed as part of the research strategy and described the

process for the collection of data. Ethical considerations in respect of recruitment to the study, consent and storage of data are discussed with relevant processes described.

Chapter 5 - Policy analysis

Introduction

This chapter addresses research question one in particular, which asks *how are midwives constructed in the discourses of policy, professionalism and learning?* As discussed in the methodology chapter, the focus of my analysis is the Standards for Pre-registration Midwifery Education [SPRME] (NMC 2009). This regulatory document provides the framework for midwifery education in both education and practice; as a discourse, it is fundamental to the construction and performance of midwifery identities in the UK. In this chapter I will present the methods used to analyse the document and the key data which emerges relative to the construction of midwives' identities.

Fairclough's three-stage conception of critical discourse analysis

For the purposes of this analysis I use the three-stage conception of critical discourse analysis theorised by Fairclough (1992, p.73) [see Figure 1 page 67]. The following three questions are the framework used to analyse the text:

1. At the level of discursive practice

   How the text is produced and consumed and in what ways does the knowledge that emerges about midwives acquire authority as constitutive of 'the truth of the matter' in the texts?

2. At the level of the text

What are the linguistic features of the text and what attributes would we expect midwives to have, given the way they are constructed in the text?

3. At the level of social practice

In what ways do these discursive practices reproduce or restructure knowledge and meanings of 'midwives' and how is this implicated in the construction and performance of student midwives' professional identities.

Discursive practice is considered, and examples presented using the concepts of interdiscursivity, intertextuality and intertextual chains. Textual analysis explores in more detail elements of SPRME and interactional control, cohesion, ethos, transitivity, and modality. Finally, social practice is exemplified using the social matrix of discourse through the concepts of hegemony and ideology.

Fairclough (1992, p.232) proposes that alongside the three-stage framework and its various analytic threads, we understand discourse as having two other features that require consideration. The first is the nature of the 'the communicative event' or 'instance of language use'. Here, the communicative event is the document SPRME. The second is 'orders of discourse' described as 'total configurations of discursive practices in particular institutions, or indeed in a whole society' (Fairclough, 1992, p.9); this is discussed in relation to the key discursive signifiers which come together to organise the identities of 'midwives'.

The production and consumption of the text

This aspect of the analysis is concerned with how the SPRME as a communicative event draws from different discourse types and how this is manifest in the document. Here, discourses are recognised as referring to 'different ways of structuring areas of knowledge and social practice' (Fairclough 1992, p.3), for example, the discourses of midwifery, medicine or professionalism. Genre is understood as not only the type of communicative event, but also how this event is produced, distributed and consumed (Fairclough 1992). As an introduction to the text, I begin by considering the front cover, an example of which can be seen in Figure 6 below.

Figure 6 - SPRME front cover

SPRME has features that make it recognisable as existing in the genre of policy documentation. The style of this document as policy is created by various means; the use of the logo, the wording, and the imagery help to animate it as such. The tone of the intended relationship between the author and interpreter

of the text is that of formality and officialdom. This is evidenced through the title: ‘Standards for pre-registration midwifery education’; ‘Standards for’ is a ‘declarative clause’ (Fairclough 1992, p.76) and uses interactional control, understood as the means to establish the relationship between the author and the reader, to set the authoritative tone of the document.

In respect of the significance of standards, Eraut (1994, p.211) provides a useful critique of the role of occupational standards and situates it within the discourses of professionalism and professionalisation. Here, the NMC through the SPRME are claiming what would-be midwives will need to achieve for entry to the profession of midwifery. It also serves as an instruction manual for those providing midwifery education as to what these standards or ‘nominalized aspects of behaviour’ (Ball 2013, p.51) entail. In doing so, it delineates subject positions in respect of not only the ‘teller’ and the ‘told’, but also considers the ‘hearer’ and the ‘overhearer’ (Fairclough 1992, p.79) and what this signifies in respect of the construction of social and professional identities. Here the teller is the NMC; however, the told, the hearers and the overhearers are slightly more ambiguous. Fairclough (1992, p.79) suggests that ‘producers within sophisticated organisations such as government departments produce texts in ways which anticipate their distribution, transformation, and consumption, and have multiple audiences built into them.’ In effect, the NMC articulates the standards to all possible stakeholders and through ‘force of utterance’ of the title (Fairclough 1992, p.75) is able to convey the text as policy.

The second conceptual thread, the ‘mode’ furthers the contextual connection between the author and interpreter and is of a formal written-to-be-read style.

This formality sets the text up as having an expository rhetorical mode, in that the function of the document is to explicate what these 'standards' for pre-registration midwifery are. The term 'pre-registration' alludes to there being a point at which these standards mediate access to a 'register', with 'midwifery education' as the means to do so. Furthermore, the title and the use of '*the* standards' presupposes that there are no alternative texts in this domain.

The concept of ideology becomes useful as an analytic device in respect of this lack of an alternative. Drawing from Althusser, Fairclough (1992, p.87) understands ideologies to be 'significations/constructions of reality (the physical world, social relations, social identities), which are built into various dimensions of the forms/meanings of discursive practices'. He furthers this with the suggestion that ideology is implicated in 'relations of domination', in this instance the power of the NMC. As a policy document SPRME arguably reflects an ideological framing of the social construction of 'midwifery' as a concept, given that there is no recognised alternative. In other words, this is 'the truth of the matter' according to the NMC. The subject position of the NMC as producer of the text dictates the terms for its consumption by its audience. Moreover, as being authoritative, prescriptive and mandatory; ergo the discursive construction of what 'policy' is.

Using Goffman, Fairclough discusses the concept of the 'text producer' (1992, p.78) and its inherent complexities. In doing so, he highlights the significance of role and function in the production of a text. The 'animator' makes the sounds or puts the words on the paper, the 'author' is responsible for putting the words together, and the 'principle' is the one whose position is represented by the

words. Here the NMC carry out all three functions. At no point in the document does it become clear who the 'collective' that is the NMC, are. This 'agentless passive' is argued by Fairclough (1992, p.182) to be politically and ideologically motivated, as it 'obfuscates agency, and hence causality and responsibility'; as such it takes an authoritative stance on the construction of midwives' identities in the UK.

Regulatory and legislative discourses that are operationalised to achieve what appears to be taken-for-granted in terms of the NMC's position and power are persuasive and seem to exist as constitutive of the 'truth of the matter' in respect of the construction of midwives. If you want to be a midwife in the UK, the NMC sets the rules by which you are expected to abide. Following criticisms of their performance as a regulator (Stephenson, 2018), the NMC now also clearly delineate where their responsibilities end. Of note is their statement that they are not responsible for 'representing or campaigning on behalf of nurses and midwives' or with 'regulating hospitals or other healthcare settings' (NMC, 2018, online). The former statement reinforces the regulatory position of the NMC; the latter is contentious given that this is where their standards, codes of behaviour and practice and the complex and challenging environments of practice within the National Health Service collide.

Policy constructs student midwives

By visualising the 'students' on the front cover of the document, the NMC shows us what student midwives 'look like'; and in doing so we start to see the emergence of the 'midwife' as being constructed through multiple and complex discourses. The concept of 'interpellation' proposed by Althusser (2000) and

utilised analytically by Fairclough (1992, p.87) becomes relevant to this discussion as how the subject is ‘interpellated’ ideologically (i.e. through discourse) into position. Fairclough criticises this concept in relation to ‘ideology’ and proposes that contrary to Althusser’s position that ideology fixes positions for subjects, subjects are capable of ‘acting creatively’ in determining their positions (Fairclough 1992, p.91). This considered, student midwives have some creative agency when it comes to self-determination.

The first discourses visibly constructing identity are those of equality, diversity and inclusion. The image suggests an organisation that positions itself as having an ethos of such. The depiction of the ‘student midwives’ signifies this, but only in respect of ethnicity and a binary representation of gender. Data published by the NMC (Nursing and Midwifery Council, 2018) do not reflect what is represented on the cover. It indicates for example, that only 0.3% of midwives are men. Black, Asian and minority ethnic groups are also underrepresented in the profession. For example, black African midwives make up 2.1%, Asian Indian 0.6% and 84.4% are white Scottish, English or Irish. Nevertheless, the NMC produces student midwives as being overtly diverse in these two contexts, neglecting perhaps other aspects of inclusion/exclusion such as disability and age.

Following this, discourses of professionalism trickle into the image in several guises. All the students are wearing a uniform of sorts, although there are differences between who is wearing what. Incongruously, it appears that the male in the picture is wearing the most formal costume, somewhat giving the impression he has been borrowed from the neighbouring school of dentistry.

That said, uniform is a means of operationalising ‘professional’ identities and can as act a rudimentary means of safeguarding the public from any would-be interlopers (MacDonald 1995). As ‘good’ professional students they wear their identification around their necks and appear to be adherent to the health and safety discourses which prescribe behaviours around appearances such as facial jewellery and hairstyle. While their lanyards are branded with the NHS logo, the students will not be employees and may be at risk of misleading ‘the public’ as to their role and function. This badge of belonging does ‘interpellate’ them into the discourses of ‘professional midwife’ and the performance of ‘NHS’ identities.

The final discourses symbolised in the image are those of risk, health and safety and bio-medicine. One of the ‘students’ wears a small bottle on her lanyard, this is anti-bacterial hand sanitiser, the uptake of this arises in the discourse of prophylaxis. It suggests that this is an organisation that recognises that those who adhere to such behaviours are demonstrating ‘good’ practice and are worthy of representation by the NMC. The elements discussed thus far combine to form ‘intertextual chains’ (Fairclough 1992, p.130) which discursively strengthen the ‘texture’ of the text as ‘policy’ and reinforce the power it has in respect of constructing midwives’ identities.

The linguistic features of the text

Regulatory power

I continue the analysis at the level of discursive practice and for the purposes of this have broken the document down into six sections. The ‘Foreword’ and

‘Introduction’ will be used to offer further insight into interdiscursive and intertextual features and will be framed in the context of production and consumption. The following five sections of the document, ‘Midwifery – the guiding principles’, ‘the Standards’, ‘Achieving the NMC Standards’, ‘Essential Skills Clusters’ and ‘EU Directives’ provide the data which is used for close textual analysis. This addresses the second stage of the analysis, which explores the linguistic features of the text in relation to the construction of midwifery identities.

In the Foreword of SPRME, the tone that is set is immediately authoritative, achieved through the use of professional, legislative and management discourses. For example, it ‘exists to safeguard’, ‘maintains a register’, ‘sets standards’, ‘deals swiftly’ (NMC 2009, p.2). It maintains this language throughout the document, but quickly introduces discourses relating to risk, education and training and biomedicine.

In this section interactional control is established through the use of the pronoun ‘we’ in respect of the NMC and the more formal use of ‘nurses and midwives’. The use of ‘we’ is suggestive of conversational discourse (Fairclough 1992, p.94). Although, as ‘nurses and midwives’ are referred to in the third person, it would appear that the conversation being had by the NMC is not with them but with the wider public or ‘stakeholders’ as they are referred to. While the standards are written for and about midwives they are addressed to a different audience, although midwives are ‘stakeholders’ too. This reinforces the expository tone of the document and begins to raise some questions around subjugated professional status and agency.

Moving the analysis to the 'Introduction' there is immediately a bombardment of intertextual references. These are described by Fairclough as 'the explicit presence of other texts in a text' (1992, p.10). In paragraph one and two the text states that the NMC is 'required by the Nursing and Midwifery Order 2001 (the order)' that it 'establishes and maintains a register of qualified nurses and midwives [Article 5(1)]', it states that the status of the standards is 'mandatory and they gain their authority from legislation', in this case, 'the Order and the NMC (Education, Registration and Registration Appeals) Rules 2004 (the Registration Rules)' (NMC 2009, p.4). The footnotes attached to some of these visually reinforce this intertextual strength (see Figure 7 below). These are visually the biggest footnotes in the document and seem almost to challenge the reader to dare to dispute any aspect of its legitimacy; in doing so they reinforce the authority of the document as 'the truth of the matter'.

[1] The Nursing and Midwifery Order 2001 (SI 2002/253) as amended by the (www.opsi.gov.uk/si/si2007/20073101) European Qualifications (Health and Social Care Professions) Regulations 2007 (SI 2007/3101), and the (www.opsi.gov.uk/si/si2008/pdf/uksi_20081485_en.pdf) Nursing and Midwifery (Amendment) Order 2008 (SI 2008/1485), The Stationery Office, Norwich, (www.hmso.gov.uk)

[2] Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 (SI 2004/1767) as amended by the Nursing and Midwifery Council, (www.opsi.gov.uk/si/si2005/uksi_20053354_en.pdf) (Education, Registration and Registration Appeals) (Amendment) Rules 2005 (SI 2005/3354) and the (www.opsi.gov.uk/si/si2007/20073101.htm) European Qualifications (Health and Social Care Professions) Regulations 2007 (SI 2007/3101), The Stationery Office, Norwich, (www.hmso.gov.uk)

Figure 7 - visual authority

Midwives 'must' 'be'

The next segment of the document 'Midwifery – the guiding principles' (NMC, 2009 p.4) shifts the focus from the NMC and their role and function, to the ways in which the NMC construct midwives and their role and function. I use two devices to explore the linguistic features of the text more closely in relation to

what Fairclough describes as ‘the ideational function of language’ (1992, p.169). These are modality and transitivity, both of which are aspects of ‘the grammar of the clause’ (ibid). The former corresponds to the ways in which social relations are set up in the discourse and how these control ‘representations of reality’, and the latter with ‘agency, the expression of causality and the attribution of responsibility’ (Fairclough, 1992, p. 235,236). With modality the verb ‘must’ is the focus of attention, and with transitivity I consider the state of ‘being’ and ‘having’ represented through the various forms of the verb ‘to be’ and ‘have’.

To mitigate the size of the document I used the qualitative data analysis software ‘NVIVO’ to conduct word counts to identify and focus on ‘must’, ‘be’ and ‘have’ (and variations thereof). This led to looking at the context within which these words sit as part of a ‘text search’, which details the terms that immediately precede and follow the words. There are two means by which this data can be viewed; a diagrammatic representation in the form of a ‘word tree’ as indicated in Figure 8 below, and as a list of occurrences as part of the text.

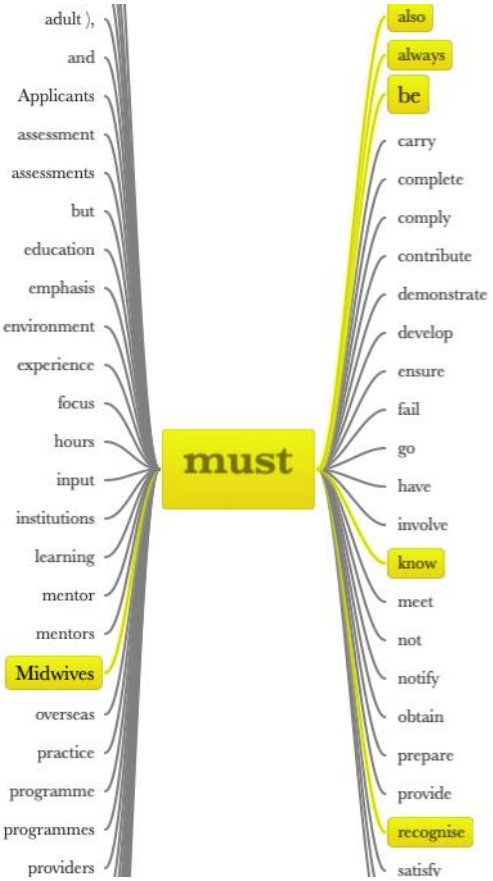


Figure 8 - NVIVO 'must'

The word tree provides not only a means to explicate key data, but also an illustration of the anatomy of a discourse; in which language through text comes together as ‘elements’ to form ‘orders of discourse’ (Fairclough 1992, p.10).

As an analytic device to explore how ‘midwives’ are discursively constructed in the SPRME in relation to modality and transitivity, NVIVO also enabled me to look more closely at how the words were used with other words in the document and build tables with which to map this. An example page from one of the tables is presented below in Table 1:

Table 1 - Transitive analysis section

Item number	Page & Para	Subject	Verb	Process – Action, event, relational, emotional
	4.5	Midwife	Is	A person
		Who	Having been	Regularly admitted to a midwifery educational programme
			Has	Successfully completed the prescribed course of studies in midwifery
			Has	Acquired the requisite qualifications
			To be	Registered to practise midwifery
	4.6	Midwife	Is	Recognised as a responsible and accountable professional
		Midwife	Has	Important task in health counselling and education
	5.2	Education programmes	Must prepare	Students to practise safely and effectively on registration assume full responsibility and accountability for practice as midwives
	5.3	Students	Must demonstrate competence in	Sound, evidence-based knowledge of facilitating the physiology of childbirth and the newborn, and be competent in applying this in practice
				Knowledge of physiological, social, emotional and spiritual factors that may positively or adversely influence normal physiology, and be competent in applying this in practice

In total five tables were compiled from the five sections of the document: ‘Midwifery – the guiding principles’, ‘the Standards’, ‘Achieving the NMC Standards’, ‘Essential Skills Clusters’ and ‘EU Directives’. Analysis of the sections as a whole indicated that each has a different expository purpose and therefore a different texture in respect of structure, style and ethos, with some yielding more data than others. The tables were developed and organised using the guidance for transitive analysis given by Fairclough (1992, p.178). He describes this as relating to two main types of process, the first is relational

‘where the verb marks a relationship’ (being, having, becoming, etc.) between participants, and ‘an action, event, relational or emotional process’, where an agent acts upon a goal (ibid). Once this was completed for the document it was easy to identify the occurrence of the verbs ‘to be’, ‘to have’ and finally ‘must’ in respect of the concept of modality. The tables were then reanalysed to look for the ‘midwife/midwives, or ‘student/s’ as the subject in relation to the verbs above. The transitive analysis details commonalities, inconsistencies and discrepancies in how the properties of ‘being’, ‘having’ and ‘must’ discursively construct midwives’ identities. Fairclough (1992, p.236) suggests that this tells us three key things in respect of ‘agency, the expression of causality and the attribution of responsibility’ and highlights who has interactional control.

As a feature of transitivity, the SPRME immediately constructs what midwives ‘are’ in the text of the Foreword: ‘midwives on our register are fit to practise’ (NMC 2009, p.2). The subject here is the midwife who exists on the NMC register. To ‘be’ here, this midwife has met all the standards that follow in the document and has paid the necessary fee to register. The next clause ‘are fit to practise’ uses the verb ‘are’ and the process action ‘fit to practise’. The use of the third person plural of ‘to be’ indicates that fitness to practise is considered by the NMC as critical to ‘being’ a midwife. Using Althusser (2000), this immediately interpellates the subject as midwife into an elaborate and rule-bound framework of behaviours and practices. Fitness to practise is described by the NMC as being concerned with misconduct, competence, health, English language skills, convictions and cautions and determinations of other regulators (NMC, 2017, p.23) with the remainder of the SPRME detailing how this is to be achieved.

The modal auxiliary verb ‘must’ occurs sixty-three times in the document. Modality as an analytic device operationalises several interpersonal functions: it enables the producer of the text to indicate a ‘degree of affinity with the proposition’ (Fairclough 1992, p.158). It can be subjective or objective in that the ‘who’ of who is making the proposition is identifiable, or not. Furthermore, objective modality affords the producer of the text a degree of ambiguity. In that, it may not be clear whether the perspective of the author is being expressed as a universal one, or whether this is a means to express the views of ‘others’. Nonetheless, the use of objective modalities ‘often implies some form of power’ (Fairclough 1992, p.159). As the conduit for the regulatory frameworks that constructs midwives’ identities, the voice of the NMC is undoubtedly significant and powerful, and where it uses ‘must’ it is unequivocal.

I have used ‘must’ to focus on those areas that help to explicate the construction of students and midwives’ identities in the SPRME. The first use is situated very early in the document in the context of ‘Safe and effective practice’ and stipulates the responsibility of ‘education programmes’ who ‘must’ design programmes to ‘prepare students to practice safely and effectively so that on registration, they can assume full responsibility and accountability for their practice as midwives’ (NMC, 2009, p.5). Here, the ideational function of language implemented by the NMC constructs the student as in transit to being fully responsible and accountable for practice at the point of registration. This has significance not only at the level of the text but also at the level of social practice, as it evidences a hegemonic intervention (responsibility and accountability) as part of an ideological imperative (standards for practice). This leaves little doubt as to the degree of affinity that the NMC has regarding these

conditions; by page 5 of the document we have been made aware on two occasions that a midwife '*is* recognised as responsible and accountable' (NMC, 2009, p.4).

The second use of 'must' and students occurs in 'Midwifery – the guiding principles' (NMC, 2009, p.5) in relation to the process of 'demonstrating competence'. This starts with a conundrum in that the '*Guiding* principles' use language that suggests anything but guidance. If 'students must demonstrate competence in' (the range of behaviours and skills which follow in the statements) there is a high degree of affinity to the proposition and little room for manoeuvre. Passive objective modality is used in the clause 'students must', a process referred to as 'the systematic mystification of agency' by Fairclough (1992, p.27).

Here, the NMC is able to control 'representations of reality' and the ways in which midwives are constructed. This is achieved through the reduction of complex, context-relevant concepts such as 'being autonomous practitioners' and 'being able to undertake critical decision-making' (NMC, 2009, p.5) to simple statements that negate influences such as agency and causality. Again, there is a presupposition that this is the 'truth of the matter' in respect of what 'must' happen. In these examples, the word 'competence' with 'must' is used three times in three consecutive statements. This 'overwording' can be seen as a sign of 'intense preoccupation pointing to peculiarities in the ideology' (Fairclough 1992, p.193).

The remaining references to students in this section and what they 'must' do, propose that they 'must understand and practise competently' (NMC 2009, p.6)

such processes as women-centred and holistic care; ethical and legal obligations; respect for individuals and communities; quality and excellence; the changing nature and context of midwifery practice; lifelong learning; and evidence-based practice and learning. Putting the challenge of demonstrating 'competence' in these areas aside, this constructs the 'student' as having a lot of work to do.

Enmeshed in the descriptions of these processes are how these 'musts' manifest at the level of 'midwife'. To illustrate, in relation to ethical and legal obligations, midwives 'must recognise their moral obligations and the need to accept personal responsibility for their own ethical choices within specific situations based on their own professional judgement' (NMC 2009, p.6). This presents the use of subjective modalities in respect of accountability for action through the use of the clause 'their' and 'their own' as regards 'the midwife' throughout. Highlighting again, the concept of 'overwording' as an indication of 'peculiarity in the ideology' and leaving little ambiguity as to who is responsible for what in this context. Helpfully, the NMC understand that 'many ethical dilemmas are complex' and propose the use of 'more than one ethical approach' (NMC 2009, p.6) to counter this nebulous issue. Presumably, whoever is responsible for this will approach this on 'their own'.

Following this, the concept of change and competence is of note, as it requires a subject who not only 'must have the capacity to adapt to change' but also 'be able to identify the need for change and initiate it' (NMC 2009, p.7). The clause 'the capacity to adapt' taps into the inherent personal characteristics of the individual and is suggestive of a flexible and responsive worker; but 'change'

like ‘ethics’ is complex and is presented free of any of the challenges of clinical and practice-related context. Despite this, midwives ‘must’ identify and initiate change as needed in an organisation where change can take years, if not decades, if at all (Mander and Murphy-Lawless 2013). This evidences interdiscursive practices drawing from the discourses of management and productivity. Fairclough (1992, p.7) situates this in a ‘post-Fordist’ context, meaning that ‘workers no longer function as individuals performing repetitive routines’ rather they are ‘enterprising, self-motivating’ and ‘self-steering’.

Co-located with this proposition and highly relevant to ‘change’ are the concepts of ‘lifelong learning (LLL)’ and ‘evidence-based practice and learning (EBP)’ (NMC 2009, p.7). The former is described as a ‘very elaborate “technology of the self” through which we shape our bodies and subjectivities to the needs of learning’ and is characteristic of the ‘pedagogisation of life’ (Ball 2013, p.133). The latter, EBP has been described as bearing ‘comparison to evangelical movements’ (Mander and Murphy-Lawless 2013) and is often contradictory to the concept of ‘woman-centeredness’ which would require the woman to be involved in the decisions that are made about her and her care. As interdiscursive elements these processes evidence the discourses mentioned above, but also of professionalism, education and medico-science. The processes of LLL and EBP are operationalised at the level of the individual by the NMC through the mandatory process of ‘Revalidation’ (NMC, 2017) and are a requirement for continuation of registration. This shapes a midwife as a subject who requires a strong sense of personal responsibility and moral obligation to self-steer through the challenges of practice.

With regard to midwives and working with 'others', midwives 'must be prepared for partnership working', this arises in 'Midwifery – the guiding principles'. The term 'partnership', is tricky; as Tomlinson (2005, p.1170) states 'Using the term "partnership" implies something about how the actors involved are expected to act in relation to one another. However, the act of naming cannot determine how these relationships will be enacted'. Furthering this, Tomlinson also cautions that the term underestimates 'the significance of power relations among the actors involved'. The 'actors' here are likely to be midwives, nurses, obstetricians, anaesthetists, general practitioners and 'other' professionals such as social workers and the police; not to mention women and their families. Failures in working practices across professional and organisational boundaries present significant challenges and require confident and skilled communicators (Kirkup, 2015; Knight *et al.*, 2019; Ockenden, 2020); to state that 'midwives must be prepared' for this, is perhaps to oversimplify professional territorialism.

Paralleled with these constructions of midwifery is the requirement to 'be' confident. These subject positions regarding 'confidence' are often immersed in difficult discourses. For example 'is confident at exploring with women the potential impact of delivery room practices'(NMC, 2009, p.20), obfuscates the meaning of what it is to be confident in exploring the 'potential impact' that their own practices may have. Hidden in this description are the discourses of risk, safety, responsibility and accountability. Similarly, 'supporting women in *normal* [my emphasis] childbirth' (ibid, p.55), essentialises birth and presupposes a discrete 'normality' that students should be confident with. This position arises in the competing discourses of midwifery and bio-medicine and is challenging terrain for the noviciate.

As a final catch-all statement in the ‘Standards’ section, the ‘student must demonstrate competence’ in the prescribed list of ‘competencies’ and ‘essential skills clusters’ (NMC 2009, p.23). This amounts to approximately five hundred and twenty separate competencies and related ‘essential skills’, thankfully the NMC informs us that this list is not ‘exhaustive’ (2009, p.23), possibly just exhausting. Significantly, the discourses of the regulatory processes in the AEI can collide with those of the profession and make things more complex. The requirement to assess progress in academic levels (SQA Level 7, 8 & 9) within Edinburgh Napier University trebles the number of competencies that ‘must’ be demonstrated to approximately one thousand five hundred. This requires a subject who is obedient, resilient and tenacious to say the least.

The social matrix of discourse

Thus far, this analysis has approached SPRME as a discursive event at the level of discursive practice and the level of the text. This section details the approaches used to address discursive constructions of the midwife and midwifery at the level of social practice. It uses the concepts of ideology and hegemony proposed by Fairclough (1992, p.87). Ideology and relevant concepts will be explored initially, with hegemony following.

Ideology

The concept of ideology employed in this analysis derives from Fairclough’s (1992, p.87) interpretations of Marxist theoretician Louis Althusser, albeit he adds with ‘important reservations’ (ibid.). Fairclough understands ideologies as ‘significations/constructions of reality (the physical world, social relations, social

identities) which are built into various dimensions of the forms/meanings of discursive practices and which contribute to the production, reproduction or transformation of relations of domination'. His caveat relates to the ways in agency and capacity for change manifests at the level of the individual, affording more scope for this as a possibility than offered by Althusser's theory. This section is concerned with the ideological imperatives of SPRME, and how they reproduce, restructure or transform knowledge in relation to midwives' identities. The 'significations and constructions of reality' are built into discursive practices in various ways. For example, SPRME and the way the text uses intertextuality and interdiscursivity as a means to strengthen its position and how it uses features of the text such as vocabulary, grammar, cohesion and style to 'constitute the subject (ibid.). Further, Fairclough makes three claims in the use of ideology as an analytic device. He argues it has a 'material existence in practices of institutions, which opens up ways to investigate discursive practices as a material form of ideology', here it is SPRME as a discursive event that creates the 'ideology' of 'midwifery' and 'midwives' as a material practice.

Moreover, the SPRME have an ideological effect and 'interpellate' subjects into the positions that it creates for them; students therefore are 'hailed' (Althusser, 2000, p.33) by the discourses therein to the subject position of 'midwife' doing 'midwifery' and all that this is prescribed to be. Finally, it offers a means to focus on an ideologically oriented discourse analysis through the concept of the 'ideological state apparatus'(institutions such as education or the media) as sites of and as having a stake in the 'struggle in and over discourse' (1992, p.87). Here, a combination of regulatory and academic ideologies reinforces the

subject positions that are available to student midwives and provide little scope for innovation or adaptation. Problematically, these can collide with the ideological positions that are made available in clinical practice, giving rise to conflicted understandings of professional identities.

Much of the content of the current document's content replicates previous versions of 'standards' for midwifery education. Since 1998, the main changes in the document are the addition of further layers of what it is that student midwives need to 'do' in the context of 'essential skills clusters' and as 'E.U. Directives' to 'be' a midwife (NMC, 2009). This is more concerned with reinforcement and less about restructuring or transforming existing knowledge. As previously discussed, what is taken for granted as the 'truth of the matter' is evidence of 'naturalised' ideologies having achieved the status of common sense over time, these embedded ideologies are the 'most effective' according to Fairclough (2010, p.87). SPRME as an effective ideology is 'structurally' located in the 'order of discourse' of many practices, for example, it reflects the discursive practices of regulation and legislation aside from its function as a piece of policy. For this analysis, it is part of the order of discourse of 'midwifery' and demonstrates an adherence to prior iterations of such.

Taking the long view, this 'order' reproduces the 'midwife' with unfailing similarities over time. For example, the requirement to be of 'good character' (NMC, 2009, p.13) is evidenced as far back as 1662 (Thomas, 2009). During which period 'good character' was confirmable to 'local churchwardens or a local clergyman' and involved a substantial fee. Presently, documented confirmation of 'good health and good character' is the responsibility of both the

student and the Lead Midwife for Education. It is part of SPRME as a ‘standard’ and therefore is a requirement for registration (which also involves a substantial fee). This constructs the ‘midwife’ in a social context as ethically and morally obliged to be ‘healthy’ and ‘good’. Defining what these terms mean in respect of this is less than straightforward and is at times contradictory to the discourses of ‘inclusivity’. There is little discussion of what constitutes ‘good health and good character’ in the literature. And yet, the AEI is required to have a ‘Fitness to Practise’ panel to mediate problematic health and character.

The strength of previous iterations of the SPRME reinforces and creates the conditions for the current document. So ‘taken for granted’ is the ideology that there is little dispute in the literature as to its legitimacy. So rigid are the prescribed attributes of the ‘midwife’ and the practices of ‘midwifery’ that as ‘events’ they do not create conditions for challenge, experimentation or change. Fairclough proposes that ‘people may find it difficult to comprehend that their normal practices could have specific ideological investments’ (Fairclough, 1992, p.90). To counter the stasis Fairclough makes the argument that education should emphasise ‘critical awareness of ideological processes in discourse’ (1992, p.90), which creates conditions for widening further the ‘theory-practice gap’ discussed interminably in the literature. As such, illustrating how the ‘state apparatus’ operates to create obedience and compliance in midwifery may undermine the professional aspirations of students.

Likened to ‘a universal social cement’ (Fairclough 1992, p.87), criticism of Althusser’s interpretation of ideology intersects at the points of agency and creativity; the midwife then is a passive recipient of an ‘ideological effect’ over

which they have little control. This takes the view that identities are somehow prefabricated in ideology and slipped on. The wearing of uniform provides a useful analogy of a material enactment of this. The ‘midwife’ is therefore positioned ideologically by SPRME in a way which ‘disguises the action and effects of the latter and gives the subject an imaginary autonomy’ (Fairclough 1992, p.90); ‘becoming’ a midwife is more automatic (with the perception of control), than agentic. It is important to consider how this ‘imaginary autonomy’ manifests at a social level.

Autonomy as a concept is regularly referred to in professional discourses, however, the ‘social matrix’ of discourse within which this concept sits does little to support midwifery autonomy. Indeed, the degree to which the ‘midwife’ is held in place discursively in respect of professional characteristics is almost irrefutable. The omnipresence of nursing is felt at a ‘structural’ level in respect of the ‘council’ and its members and while the medical profession is represented there too, they are much more visible in the discursive ‘event’ that is SPRME. Medicine’s presence is felt in SPRME as part of the IDM as adopted by (FIGO) in the introduction, as ‘others’ in the ‘competencies’ and ‘essential skills clusters’ referral to whom is required when ‘care requires expertise beyond the midwife’s current competence’, and as ‘the doctor’ who almost gets the last word of the document (NMC 2009, p.4,52,69). Of interest is that the term ‘others’ is used in the bulk of the text as a device that precludes the mention of ‘doctor’, ‘obstetrician’ or any other category of medical professional.

As a rhetorical device this enables the NMC to foreground ‘midwifery autonomy’, although ‘medical dominance’ hovers concomitantly throughout. For

example, in sustaining ‘emergency measures until help arrives’ (NMC, 2009, p.51) that ‘help’ is undoubtedly medical. Similarly, the ‘appropriate professional’ to call ‘when care requires expertise beyond the midwife’s current practice, (ibid, p.51) or the needs of the woman or baby fall outside the scope of midwifery practice’ is unquestionably doctorly. Ideologically, this acts to delineate those professional boundaries that should not be transgressed and as a discursive practice maintains the status of midwifery as inferior to medicine.

The concluding annexe, which reflects an imported E.U. voice and therefore a different ethos, is much more direct in its positioning of the midwife as subjugated to the doctor. For example, in the statements: ‘To recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor’s absence and ‘To carry out treatment prescribed by a doctor’ (NMC 2009, p.69). This reflects cultural variance in respect of E.U. constructions of identities and reinforces the ‘midwife’ as a contested site of professionalisation. Such is the prescriptive nature of SPRME that it is not difficult to understand how practitioners ‘come to be indoctrinated with an ethical sense of limited responsibility’ as suggested by Merton (1947, p.80), this despite the ideological imperative to be fully responsible and accountable for their practice. Merton also proposes Thorstein Veblen’s concept of ‘trained incapacity’ in respect of dysfunctional bureaucracy limiting professional scope, something that possibly resonates here.

Disruption is possible however, as will be seen in the small story analysis where there is ‘critique and opposition to’ (Fairclough 1992, p.90) the ideological

practices of the SPRME voiced by student midwives. This is described as ‘contradictory interpellation’ (ibid.) and although subtle, can demonstrate the emergence of identities resistant to those which are ideologically ascribed. Fairclough offers a caveat that all discourses are ‘not irredeemably ideological’ and that ‘so far as human beings are capable of transcending such societies (as class, gender, cultural groups etc.), they are capable of transcending ideology’.

Hegemony

If ideology is how subjects are discursively constituted, ‘hegemony’ is the device through which discourses prevail, are rearticulated, or dissolve. Fairclough (1992) draws from the theory of hegemony proposed by Gramsci (1971) and Laclau and Mouffe (1985;2015); suggesting that it can be understood in two ways, as a matrix and as a model.

As a matrix, the ‘hegemony’ of ‘midwives’ and ‘midwifery’ requires a ‘degree of integration of local and semi-autonomous institutions, and power relations’ (Fairclough, 1992, p.92). Here SPRME draws on the power of the ‘Approved Education Institution’ to reinforce its hegemonic strategy. ‘Approval’ in this instance means that the programme that has been prepared meets the standards set out in SPRME, and has been audited by an NMC and NHS Education for Scotland (NES) appointed approval panel. Thus, hegemony is achieved in respect of the social construction of ‘midwives’ through the integration of powerful institutions and the discourses therein.

As a model, the concept of hegemony becomes significant as the 'theory of the decision taken in an undecidable terrain' (Laclau and Mouffe 2015, p xi), in other words, what comes to be taken for granted or appears as common sense over time. In the context of the SPRME this relates to how intertextuality, interdiscursivity, lexical and grammatical features combine to temporarily 'fix' the meaning of 'midwife' discursively. Gee (2014, p.28) suggests that discourses 'talk' to us, he also cautions that if they 'cannot inhabit minds and bodies, they die in history'; the NMC through SPRME has the power to give voice to important midwifery discourses, but also to silence them. Hegemony, however, is 'never achieved more than partially and temporarily' (Fairclough, 1992, p. 92) and as such discursive constructions of 'midwives' are not fixed. Importantly, this creates the possibility for change.

In as much as hegemony is 'domination across the economic, political, cultural and ideological domains of a society' it is also as much about leadership (Fairclough 1992, p.91). Leadership as a feature of the NMC through SPRME is difficult to ascertain, as the organisation is 'faceless'; that it leads is difficult to dispute. Criticisms are levied at the NMC as to how 'consultative' consultation has been and is currently in respect of policy development (Stephenson, 2018), and just as identities are ideologically 'prefigured' there are some who believe that the same applies to policy (Humes and Bryce, 2003; Bourke, Ryan and Lidstone, 2013; Ball, 2015). There appears to be little evidence of discursive 'struggle' in the profession in respect of attempts at transformation, and where this is attempted, the outcomes are often not in favour of the protagonists. Fairclough discusses the use of 'covert markers of power asymmetry' and how they 'become more potent' through what is described as 'formulating rights'

(1992, p.203), here it seems that there are particularly ‘overt’ markers demarcating the balance of power.

Conclusion

As a feature of discursive practice, students are constructed in the context of regulatory understandings of what it is to be a midwife. More broadly, the NMC constructs students within the discourses of equality, diversity and inclusion by way of visual representation. Further, the discourses of health and safety and professionalism are surfaced through artefacts such as the lanyards and the wearing of uniform. Closer analysis of the standards brings the discourses of professionalism into view; articulated through concepts such as competence, confidence and the somewhat nebulous ‘good health and good character’ required. The discourses of risk and safety emerge with the requirement for students to demonstrate evidence-based practice and lifelong learning. A strong sense of regulatory power is achieved through medico-legal discourses that reinforce the position of the NMC, particularly regarding what students ‘must’ do. This can be readily seen with the requirement to ‘be’ accountable, responsible and autonomous practitioners. These too are features of the managerialising/productivity discourses that seek to organise the subject positions that are available to the students. The discourses of women-centred care are presented in the document and as far as the meaning of this is understood, occur in the main as a ‘taken-for-granted’ aspect of care.

The ‘midwives’ constructed in the SPRME then are regulatory hegemony; they are brought forth in the discourses of the SPRME and reflect the ideological imperatives of the NMC. The constructions that prevail are subject to the

conditions within which hegemony can be undermined, disrupted and even dissolved. Social identities such as these are, according to Laclau and Mouffe (2015), always established relationally; in relation to something that they are not. The analysis considers the subject positions the SPRME makes available to ‘midwives’ and in doing so identifies that there is a requirement to ‘be’ many things; responsible, accountable, autonomous, professional, competent and confident amongst others.

These ‘midwives’ are singularly reified in relation to the regulatory requirements and are not informed by any other perspectives. This absence of multi-perspectivism requires exploration of the impact that ‘context’ has in the construction and performance of midwives’ identities and is the focus of Chapters 6 and 7.

Chapter 6 - Small story and micro-drama analysis

Introduction - using parts to explore the whole

Having discussed the ways in which policy constructs midwives, I now consider the ways in which student midwives construct and perform their professional identities. The following chapter addresses research questions two, three and four. It presents an 'exemplar' of the small story and micro-drama analysis that has been applied to each of the sixteen participants. It provides the full transcript, small story and micro-drama analysis and the different ways in which these are methodologically employed to illustrate aspects of professional identity. The aim of this is to provide one participant's analysis in its entirety so that the broader context of the other participants analyses presented in Chapter 7 can be understood.

Participant 1 - exemplar

The Participant

P1 is a third-year student midwife who commenced the programme immediately following her secondary education. The analysis uses Bamberg and Georgeakopoulos's (2008) three levels of positioning set out in Chapter 3, which in turn deal with: the story's characters and how they are relationally positioned; how the narrator positions herself (and is positioned) within this situation; and how the narrator positions her identities in respect of wider/dominant discourses.

The small story that is presented reflects the interview that was conducted with P1 in its entirety, as such it presents what Georgakopoulou (2015, p.255) describes as an atypical and sometimes messy ‘story’. The micro-dramas are incorporated into the transcript using the images as discussed in Chapter 3. Any gestures that are presented in the transcript originate from a static position, and are significant to the analysis.

Participant 1 – Transcript (see Appendix 1 for conventions)

The text of the transcript is presented in italics; as such, italics are used in all the analyses to represent what has been said during the interview.

1	CM	*okay so the first thing that I am going to ask is+*
2		*is can you remember*
3		*when you first encountered this piece of equipment*?

Figure 9 - hands on hips

4	P1	*yeah [glances at equipment hands on hips then looks at me – continues to look at me]*
5	CM	*yeah*
6	P1	*in first year*

7	CM	*and what did it feel like when you first learned how to do*
8		*this with this particular piece of equipment?*
9	P1	*it's quite difficult*
10	CM	*uhuh uhuh*
11	P1	*you think+ I don't know+*
12		*I think like you think you're never going to be able to do it*
13		*but once you get out into practice it's completely different*
14		*it's not it's not the same thing at all I don't feel like [does*
15		*not touch equipment at this stage, hands still on hips, looking at me]*
16	CM	*and can you can you remember+ how did you feel about*
17		*learning how to do it? did it feel+ you know+ did it feel*
18		*exciting+ did it feel?*
19	P1	*yeah it was quite exciting+ but I think it's one of these*
20		*things that it is actually quite a big responsibility as well*
21		*because if a baby's breech*
22		*oh obviously if you don't pick it up*
23		*it can be quite a big thing when the woman goes into labour*
24		*yeah but it's quite exciting I don't know why [glances at*
25		*equipment] I just really like abdominal palpation*
26		*when the babies kick out at you and things*
27		*I think that's quite an exciting part of the job*
28	CM	*like the contact of it?*
29	P1	*yeah*
30	CM	*em so I asked you how you felt about doing it then+*
31		*how does it feel seeing the equipment now*?
32	P1	*[looks at equipment, doesn't touch it]*
33		*a lot more+ you'd be a lot more relaxed*
34		*and you know what it's all for+*
35		*yeah I feel quite comfortable with it all*
36	CM	*so you wouldn't feel+ perhaps when you saw it the first time*
37		*you might have felt a little bit anxious about+*
38		*you know+ oh god what does this mean+*
39		*what am I going to do with it?*
40	P1	*yeah hmm yeah+ you nearly feel like*
41		*you're never going to be able to tell what way a baby's lying*
42		*where the back is where++ but you do+*
43		*and you're never going to be able to tell the difference*
44		*between a head and a bum+ but you do you get* there
45		*[glances at equipment]*
46	CM	*ok++ these things here+ do you use these things?*

47 P1 *[picks up sonic aid glances at Pinard] yeah mmh huh*

Figure 10 - holds and pats Doppler

48 *this+ the sonic aid*

Figure 11 - hovers hand over Pinard

49 *a lot more than the++ [keeps hold of*
50 *Doppler and pats top of Pinard then pats Doppler]*

51 CM *uhuh huh and can you talk a little bit more about+*
52 *so you use that more than that one?*

53 P1 *yeah*

54 CM *why do think that is?*

Figure 12 - looks at Doppler

55	P1	*I think it's+ I just think it's the practice of your mentors*
56		*and this is what they go for*
57	CM	*uhuh*
58	P1	*obviously my community mentor is really good*
59		*she always gets em+ the Pinard out and she [keeps holding*
60		*sonic aid and hovers hand over Pinard]*
61		*because obviously it's one of our competencies*
62		*and she always goes over it with me+*

Figure 13 - hovers hand over Pinard

63		*but I think it's more because the mum can't hear it [hovers*

64 *hand over Pinard]*

65 CM *uhuh*

66 P1 *but obviously it's such a skill that you really need as well*
67 *to be able to listen with the Pinard because*
68 *my community mentor said if you're out at a home birth*
69 *and your sonic aid runs out of batteries*
70 *you need to be able to pick up your Pinard*
71 *and be able to auscultate [glances at Pinard] emm*

Figure 14 - pats Doppler

72 *but I think it's because the mum can hear it too here+*
73 *and it's a lot nicer for her*
74 *I think it's nearly one of the nicest things*
75 *about their antenatal appointment+*
76 *is being able to relax about when they hear the heartbeat*

77 CM *mmhuh and do you feel comfortable about using that one?*

Figure 15 - glances at Pinard pats Doppler

78 P1 *[glances at Pinard] not as-as comfortable [pats Doppler]*
79 *as I feel using this+ just because++*

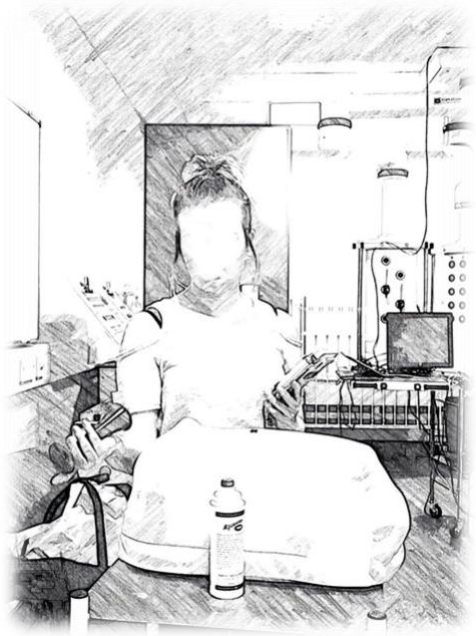


Figure 16 - picks up Pinard keeps at arm's length

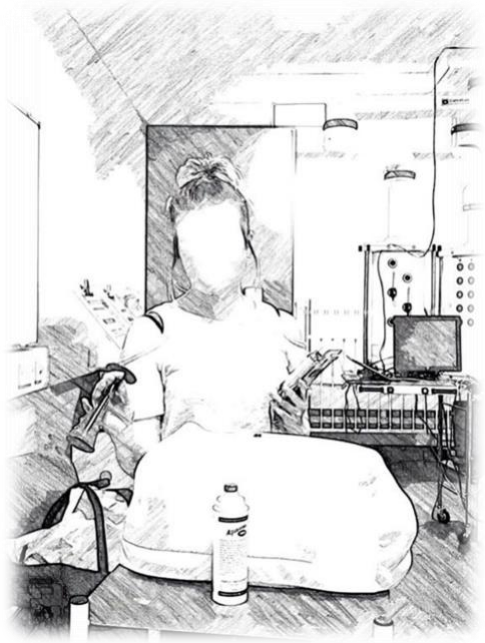


Figure 17 - looks in one end of Pinard then the other

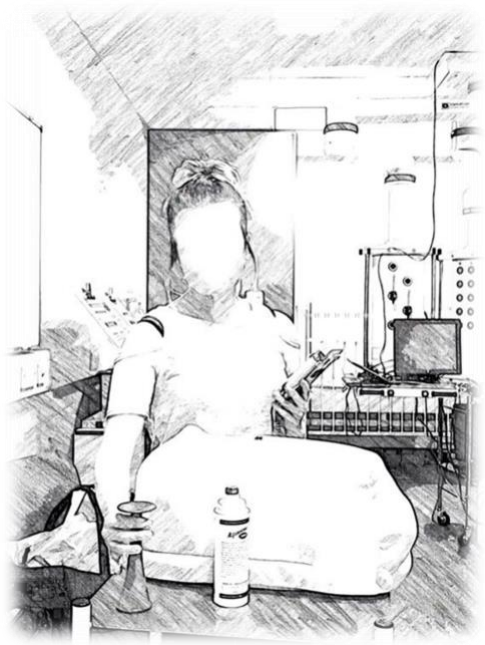


Figure 18 - puts Pinard back down

80 *I don't think we get enough practise- [holds sonic aid with two*
81 *hands] well= don't get enough practise*

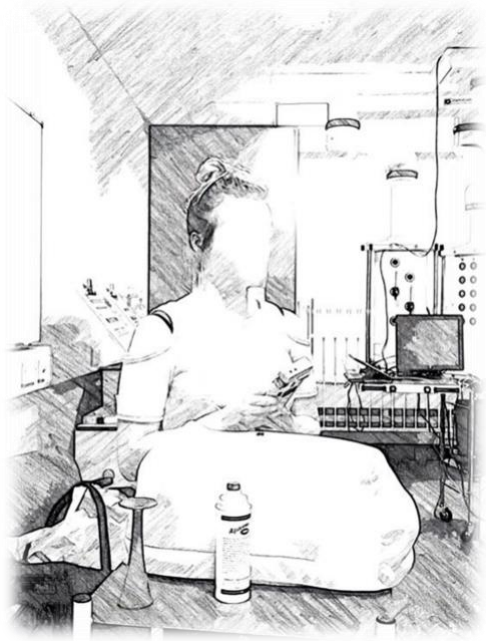


Figure 19 - holds Doppler with both hands

82		*it's probably something we should be doing a bit more++*
83	CM	*and do they use them in the hospital?*
84	P1	*I've <u>never</u> <u>ever</u> seen one being used in the hospital*
85	CM	*right*
86	P1	*I done one+ a placement in the birth centre*
87		*a woman had on her birth plan that she only ever=*
88		*that she only wanted her baby auscultated*

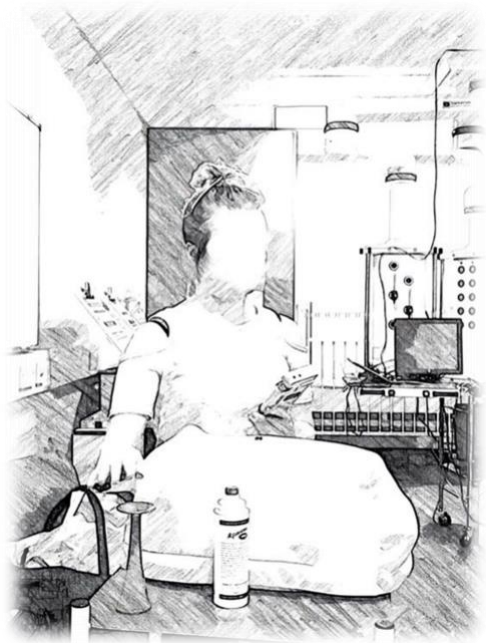


Figure 20 - hovers hand over Pinard

by the Pinard [hovers hand over Pinard] and all the midwives were like [raises hands with Doppler in one and looks up]

Figure 21 - raises hands and rolls eyes

<u>oh</u> I'm not going in there

CM */[laugh]*

P1 */[laugh]\ but I think it's just because it's not a skill they keep up to date either+ [sonic aid in both hands]*

CM *uhuh and did she manage to have her birth with just the Pinard?*

P1 *uhuh yeah I think she did*

CM *<u>wow</u>!*

P1 *yeah I think it was one of the more senior midwives went in and done it for her yeah but everyone was a bit like [shakes head] I'm not having <u>her</u>*

CM *yeah+ I'm not going in <u>that</u> room*

P1 *yeah*

CM *and do you think looking back on this as a way of learning about something do you think it was a useful thing to do?*

P1 *definitely yeah*

CM *yeah*

110 P1 *it definitely gets you prepared*
111 *and gets you thinking about it*

Figure 22 - 'palpates' without touching model

112 *to go through it and the systematic approach [makes hand*
113 *gestures of palpation in air, but doesn't touch model, still*
114 *holding sonic aid with both hands]*
115 *because obviously there is a systematic process*
116 *that you need to do for an abdominal palpation*
117 *and it just prepares you for going out into practice*
118 *and you're not in the clinic room thinking that*
119 *aaaah I don't know where to start*

120 CM *uhuh*

121 P1 *even if you are just feeling*
122 *and you don't know what you're feeling+*
123 *you just say+ I just always said to my mentor+*
124 *I have no clue*

125 CM *[laughter] right*

126 P1 *and then she would do it [makes palpation gestures in air]*
127 *and then say right this is what I am feeling you do it again*
128 *and that's how I learned by her*
129 *you know if I didn't know what I was feeling*
130 *she would talk me through it and then you do get to feel*
131 *like right that's ok I do know that that's-*

132 CM *so it helps you to get into the sort of*
133 *rhythm of doing it perhaps?*

134 P1 *uhuh*

135 CM *and do you think you still use the same sort of approach*
136 *that you learned right at the start? or?*

137 P1 *yeah yeah I always come in at the fundus [hovers hands*
138 *over model and 'palpates'] and come + hold at one hand*
139 *and + come down one side*

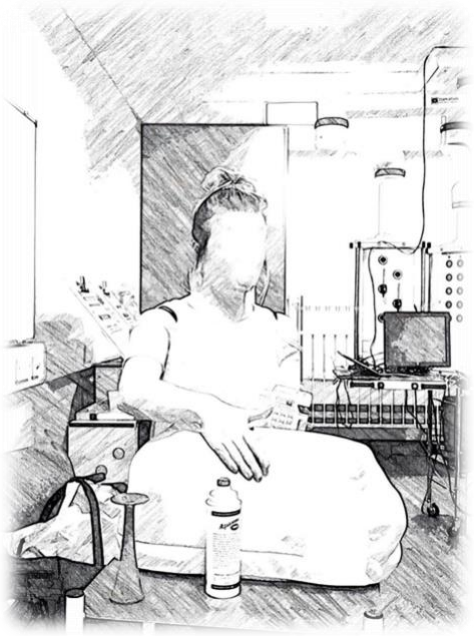


Figure 23 - touches model and palpates

140 *[touches model for first time]*
141 *and then support with the other hand*
142 *and come down this side [still doesn't put down sonic aid]*

143 CM *mhuh*

144 P1 *and feel for the head as well*
145 *yeah so I definitely still use that*

146 CM *mhuh it's like riding a bike isn't it [laughter]*

147 P1 *[laughter] uhuh yeah*

148 CM *and in comparison to how you felt about doing this then*
149 *when you first started do you feel different doing it now?*
150 *not with this + but out there with women?*

151 P1 *uhuh yeah I am definitely a lot more confident with it now*

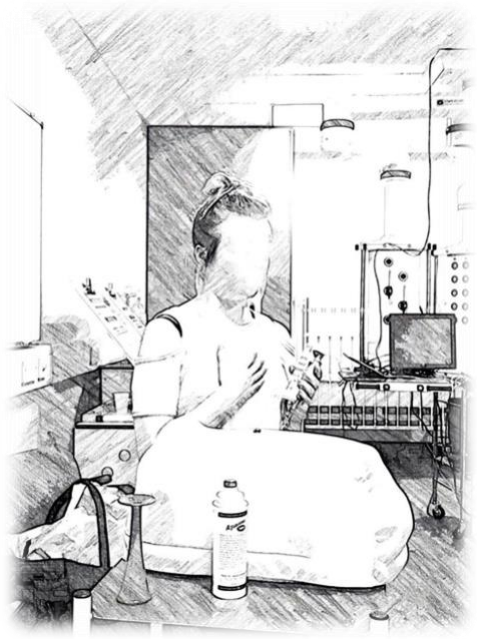


Figure 24 - touches 'I'

153		*at the start I never wanted to say to the woman*
154		*oh this is your baby's back [hovers hand over side of model]*
155		*and this cos I thought if my mentor comes and*
156		*she says actually that's not your baby+*
157		*your baby+ your baby's back's here [hovers hand over other side]*
158	CM	*[laughter]*
159	P1	*or your baby's breech and you were like ahhhhh*
160	CM	*yeah+ or it's two babies [laughter]*
161	P1	*[laughter] but I feel a lot more confident now with it*
162		*that you can just say yeah this is what I'm feeling [hovers*
163		*hand over abdomen] and you can see with your*
164		*with the change in your mentor*
165		*where she's quite happy as well+ unless you=*
166		*I think you see with your caseloading*
167		*my mentor was quite relaxed and happy*
168		*that if I had a concern or I didn't know what this was*
169		*that I was going to say I'm not sure*
170		*you+ I felt a lot more confident to say*
171		*actually this is the way your baby's lying [hand is making*
172		*palpation gestures] and that's all+ that's all normal+*
173		*that's all good*
174	CM	*uhuh*
175	P1	*and if I thought mmm I'm not sure if that's a head*
176		*or a bum down there [uses hand to make 'balloting*

177		*movement*[7]*] or I would just say to my mentor*
178		*can you double check that palpation for me?*
179	CM	*that's great good+ that's all I needed to know*
180	P1	*okay*
181	CM	*that's great+ thank you so much*
182	P1	*no problem*

Interview ends

Positioning Level 1 - who are the characters and how are they relationally positioned?

This level details how characters are positioned within the story in space and time. It explores who the teller is and the story that they are telling. It aims to understand how the characters are constructed and how they are characterised throughout the small story. It also explores what the tale world is and what the audience can take into account from these descriptions.

In summary, P1's story moves through a number of different scenes and scenarios. Initially, she discusses her views regarding the use of learning about abdominal palpation and situates this in relation to possible adverse outcomes of not doing it properly. She follows this with her appraisal of the Pinard and the Doppler and which is used more in practice. This leads to her telling of a seemingly controversial incident that happens in the clinical setting that has the Pinard as the central character *(line 86)*. From here, P1 goes on to discuss her

[7] 'Literally – bouncing. Elicited in examination per abdomen when head not engaged; fetal head tapped on one side, floats away, returns against examining fingers' (Tiran, 2017, p.21)

emerging identity as a more confident practitioner through her descriptions of performing abdominal palpation.

P1 introduces us to a number of characters, some with more significance than others. Initially, we are introduced to *you* as in *you never think you are going to be able to do it (line 12)*. Through *you* we encounter a somewhat passive agent of the experiences that happen in the small story. Fairclough describes this as a means of decentring direct responsibility for the statements which are made, which serves to illustrate 'ideational' dimensions of the grammar of the clause (1992, p.179). In other words, P1's use of *you* allows her to take the position of a student midwife or midwife, without assuming direct responsibility for the statements that she makes. In doing so P1 distances herself from direct accountability as she constructs her story.

In the here and now of the interview setting this tentative use of language characterises P1 as having a position on some of the issues raised, but she chooses to state them carefully. P1 refers to herself in the first person '*I'* on fewer occasions and in conjunction with statements to which she is happy to give a more authoritative position: *I think that it's+ I just think it's the practice of your mentors (line 55); I think it's nearly one of the nicest things (line 74); I've <u>never</u> <u>ever</u> seen one being used in the hospital (line 84).* With the language choices that she makes P1 positions herself as happier to tell me what she thinks than what she knows. P1 then brings in *babies* who are found out in *practice* and are characterised as having their own qualities. For example, they might engender a sense of responsibility if they are *breech*[8] and *you don't pick*

[8] Breech presentation occurs in 3-4% of pregnancies and is currently considered to be an obstetric emergency if it remains undiagnosed at term (Impey, LWM., Murphy, DJ., Griffiths, M.,

it up (line 22), or they may cause *you* to question your capabilities as a student as you may *nearly feel like you're never going to be able to tell what way a baby's lying (lines 40,41)*. Babies can also be a source of pleasure *when they kick out at you and things (line 26)* which for P1 is *an exciting part of the job (line 27).*

The *woman* is characterised as anonymous and passive to the responsibility that P1 experiences in relation to abdominal palpation *if a baby's breech it can be quite a big thing when the woman goes into labour (line 23)*. Here P1 describes midwifery care as *it* and the challenge and complexity of decision-making regarding breech birth as *quite a big thing*, secondary to *you* and the responsibility that *you* have in this scenario if *you don't pick it up*. *Woman* then becomes *the mum,* a more informal character for whom P1 thinks hearing the fetal heart with the Doppler is *a lot nicer (line 73)* than the Pinard; in fact, P1 thinks *it's nearly one of the nicest things about their antenatal appointment+ is being able to relax about when they hear the heartbeat (lines 74-76)*. Quite for whom the relaxation occurs upon hearing the fetal heart is rather more ambiguous.

The characters of the Pinard and the Doppler are central to the developing story and emerge in relation to one of the questions that I ask P1 *these things here+ do you use these things? (line 46).* In her response, the Doppler is characterised as being used because it is what it is her mentors do, and the Pinard is characterised as being used because *obviously it's one of our competencies (line 61)*. P1 evaluates this with the statement *but I think it's more*

Penna, LK., 2017). The publication of a controversial international study in 2000 (Hannah *et al.*, 2000) had a significant impact on the management of breech birth.

because the mum can't hear it [hovers hand over Pinard] (line 63 Figure 15), placing the benefits of the shared acoustics of the Doppler over the perceived technological limitations of the Pinard as her understanding of why it is used more. In the context of this discussion, the *really good (line 58)* community mentor is introduced and is characterised as helpful and informative, helping P1 achieve her competencies and giving advice as to why the Pinard is a significant aspect of practice.

The characters that emerge in the next part of the transcript are *a woman*, *midwives* and a *senior midwife (lines 87,89,100)*. They are positioned in relation to each other as the intended recipient of care and those who are responsible for giving the care, all are anonymous. In terms of events, the woman has *on her birth plan* that she *only ever- that she only (lines 87,88)* wants the fetal heart auscultated with a Pinard in respect of the care she receives and *all the midwives (line 89)* are positioned as refusing *oh I'm not going in there; I'm not having her (lines 91,102).* Responding to a question from myself as to whether the woman ended up having her birth with a midwife just using the Pinard, the story ends with P1 saying *yeah I think it was one of the more senior midwives went in and done it for her (lines 100,101).*

P1 does not position herself within the story of the birth centre, other than to say that she was on a placement there. There is no sign that she was there when the story took place. Presenting it as this does not diminish the value of the story. Bamberg and Georgakopoulou (2008, p.6) also cite Goffman's (1981) notion of the 'participation framework' to illustrate this. This framework uses the categories of author, animator and principal with regard to the roles such as

those played by P1 in the tale. As the author, P1 reveals the tale and the 'taleworld' (Bamberg and Georgakopoulou, 2008, p.9). As animator, she takes on the identity of the midwives and positions their reluctance to give care, through this testimony P1 gives a suggestion of having been there. Although she does not associate herself with the principals (midwives) in any overt way. Despite this, Bamberg and Georgakopoulou (2008, p.15) attest that this lack of direct involvement and implication in stories narrated like this are still 'of extreme relevance for what kind of identity is under construction.' P1 uses the story to raise practice related dilemmas, making me aware of the experience and inadvertently constructing herself in relation to this as she does.

The woman in the birth centre is characterised as expressing she *only ever, that she only wanted her baby auscultated (line 88)* the emphasis and repetition of *only* and the use of *ever* indicating the perceived significance to the woman of the act being described. From here, P1 shifts the statement from *only ever* to *only*, the change decreasing the force of the statement that is made. The woman is also depicted as *in there (line 91),* which separates her from the rest of the characters in the tale and positions her as 'other'. The *midwives* are portrayed as reluctant to participate in care, possibly on account of being deskilled in the practice of Pinard auscultation *I think it's just because it's not a skill they keep up to date with either (lines 93,94)*. The upshot is a refusal by the midwives to go into the room and be with the woman (ergo not very 'mid-wife') *I'm not having her (line 102).* The midwife who does go into the room is characterised as '*senio*r' but there is no accounting for whether this means that she is skilled and competent, or possibly brave (or just old) enough to take on the responsibility of doing *it* for the woman.

Positioning Level 2 - the interactive accomplishment of 'narrating' – why is it told this way?

This level explores what is told and why it is told this way. Here we are looking to see how P1 positions herself within the story and why she articulates it to me the way that she does. It has a focus on the 'interactive accomplishment of narrating' (Bamberg and Georgakopoulou, 2008, p.10) and proposes that it is through the subject positions created in the telling of stories that identities emerge. In order to analyse narrative data in this way Bamberg and Georgakopoulou (2008, p.10) suggest looking for narrative elements citing Bauman (2004, p.6) and the identification of 'generic framing devices' as a means to do so. For example, the way in which P1 responds to my question asking her about how she felt learning abdominal palpation. Her reply frames her experience in the context of the diagnosis of breech presentations:

> *it is actually quite a big responsibility as well*
> *because if a baby's breech*
> *oh obviously if you don't pick it up*
> *it can be quite a big thing when the woman goes into labour (lines 20-23)*

P2 sets up an expectation of something interesting to come with the statement *it is actually quite a big responsibility*. She is telling me that she is aware of the significance of the skill and what the purpose of doing it is. In using the term *obviously,* P1 shares that is obvious to us as midwives about this practice and that she knows that detecting the presentation of the fetus is important particularly if *you don't pick it up*. P1 indicates that she is aware of the accountability for action that is integral to the practice of abdominal palpation;

that it is not just about what you do, it is also about what you do next. Of interest is the next statement that if you don't pick up the breech *it can be quite a big thing when the woman goes into labour*; it would be fair to say that this is somewhat of an understatement in the context of breech presentation and birth. This seemingly naïve perspective is possibly a rhetorical device employed to let me know that P2 is fully aware of what it means to be a responsible and accountable practitioner without her having to elaborate; or not. P1 possibly indicates this to me in order that I as a midwifery lecturer, understand her identification with what it is to be responsible and accountable and therefore a 'good' student midwife.

P1 concludes this part of the interview saying she *just really likes abdominal palpation when the babies kick out at you and things (lines 25,26).* This is possibly to make me as feel satisfied that teaching abdominal palpation is a worthwhile aspect of the educational process and also to reinforce that P1 enjoys the practical skill being discussed.

Having been fairly still up to this point, asking P1 the question *these things here+ do you use these things? (line 46)* prompts her to move and pick up the Doppler. From here the Doppler and the Pinard emerge as key characters in the small story.

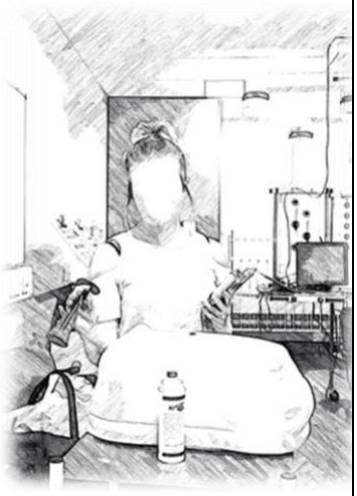
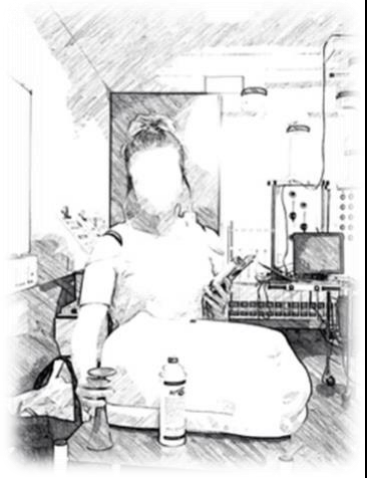
Stories within stories: The Doppler and the Pinard

The introduction of the Doppler and the Pinard as characters shifts the direction of the story. P1 picks up the Doppler stating she uses *this+ the sonic aid a lot more than the++ (lines 48,49 & Figures 14 & 15)*. As P2 pauses, she pats the

top of the Pinard but does not name it and I wonder at this point if her hesitation relates to her having forgotten the name of the Pinard. P1 describes that the Doppler is used more on account of *it's the practice of your mentors and this is what they go for (line 55 Figure 16)* and P1 acknowledges the Pinard is significant to 'good' midwifery practice as she goes on to state that *obviously my community mentor is really good she always gets em+ the Pinard out (lines 58,59)*. P1 is reassuring me that as auscultation with the Pinard is *obviously* one of her competencies; her *good* mentor is abiding by the requirements of the SPRME (NMC, 2009). As she does this, she continues to hold the Doppler and periodically glances at the Pinard. In doing so, it seems she wants me to feel reassured that she is doing what she needs to be 'competent'.

The Pinard and the Doppler are significant to the small story as it develops and are fundamental to the concurrent micro-drama. When I ask P1 if she feels *comfortable about using that one (line 77)* as I point to the Pinard, the following micro-drama presented in Table 2 (below) occurs:

Table 2 - P1 Frames for analysis

Transcript – P1 small story and micro-drama frames for analysis		
		
Frame 1 - glances at Pinard pats Doppler	*Frame 2 - picks up Pinard keeps at arm's length*	*Frame 3 - looks in one end of the Pinard then the other*
not as-as comfortable as I feel using this+ just because	+	+
		
Frame 4 - puts Pinard back down	*Frame 5 - holds Doppler with both hands*	
I don't think we get enough practise-well- don't get enough practise	*it's probably something we should be doing a bit more++*	

P1 pats the Doppler and tells me *not as as comfortable as I feel using this+ just because++ (Frame 1),* during the pause she picks up the Pinard, looks in either end, and puts it down again. After she puts it down, she holds on to the Doppler with both hands and says *I don't think we get enough practise- well don't get enough practise it's probably something we should be doing a bit more++*

(Frames 4 & 5). P1's gestures fill the pause in her narrative and tell a story relating to her confidence with the Pinard that may have not come to light were it an audio recording. This micro-drama, the fleeting nature of her engagement with the Pinard, tells me that it is something that is not a part of her repertoire of skills. Using this 'iconic and indexical' gesture, P1 gives a picture of her 'state of mind, feelings and intentions towards the Pinard' (Janney, 1999, p.960). She embodies in seconds, the contested discourses implicated in her practice regarding auscultation of the fetal heart.

While P1 describes not getting enough practice with the Pinard, she does not determine the environment that this practice should take place in. P1's *community mentor* is presented as *obviously really good*, because *she always gets em the Pinard out (lines 58,59).* I am told this mentor presents a robust argument for the skill of using a Pinard *because obviously is such a skill that you really need as well (line 66)*. P1's mentor recommends learning the skill just in case you might be *out at a home birth* and find yourself in a situation where *your sonic aid runs out of batteries (lines 68,69)*; in which case, P1 stresses, *you need to be able to pick up your Pinard and auscultate (lines 70,71)*. Or make sure you carry spare batteries.

P1 shares that her *good* mentor is helping her to achieve the competencies required and that the mentor is sharing the rationale for achieving them. In doing so P1 is indicating to me that she wants to be understood as competent in this aspect of practice. The mentor *always goes over it (line 62)* with P1 signifying their repeated commitment to the use of the Pinard, but in the here-and-now of the interview P1 still does not pick it up.

The tale of the woman in the birth centre

Following the pause at the end of *it's probably something we should be doing a bit more++ (line 82)* I ask P1 whether she has seen the Pinard being used in the hospital. From here, we hear a story that elaborates on P1's perception of its lack of use in practice. Her answer to the contrary *I've never ever seen one being used in the hospital [shakes head] (line 84)* and the subsequent tale of the *woman* in the birth centre who only wants the Pinard used, as somehow different and unusual.

P1's introduction to the story *I done one, a placement in the birth centre*[9] *(line 86)* is built upon her previous statement of having *never ever seen one being used in the hospital*. This sets up an expectation to the audience that there is a story to follow which is set in a site of possible interest and controversy. In doing so P1 boosts the tellability of the tale.

The birth centre is a clinical environment to which labouring women are 'admitted' if they fall within certain defined parameters of 'normality' (NHS Quality Improvement Scotland, 2009). The ethical dimensions of admission to such environments have been explored in relation to the 'over-reliance on abstract calculations of risk' (Scamell, 2014, p.813) concluding that inclusion rather than exclusion, regardless of status is appropriate. As per NHS Lothian's

[9] As an example of how the concept of the birth centre is described to the general public, NHS Lothian on their website state (verbatim text): The state-of-the-art facility has been designed and built to give women more choice about the birth of their baby. It will be one of a (sic) options available to expectant mums in Lothian, alongside hospital and home births. The birth centre mixes the best of both previous options and offers women a more "homely" environment with all of the advantages of hospital medical expertise nearby. It has six bright and airy delivery rooms, each with their own en-suite facilities, a dedicated birthing pool and equipment to help women feel more comfortable during labour, including birth balls, mats and pillows. Around 1,500 women a year, who are assessed as being unlikely to require high-tech medical interventions, will be able to have their babies in the more "homely" environment.

description, women who are ‘assessed as being unlikely to require high-tech medical interventions’ are eligible to choose this option, although how much ‘choice’ there is, is also contentious (Coxon, Sandall and Fulop, 2014). This ‘choice’ is also contingent on how women anticipate they will cope with the pain of labour; for women experiencing their first and subsequent children, this perspective is heavily influenced by their own constructions and experiences of birth and pain (Luce *et al.*, 2016). Furthermore, as anaesthetic cover is not part of the services provided by the birth centre, those who might be considering an epidural[10] would not choose this as a place to give birth. Instead, they might attend a ‘Labour Ward’ or a ‘Delivery Suite’ in a hospital. Here P1 is alluding to the ‘type’ of woman who uses the birth-centre in her use of this term at the start of her recollection. This is immediately reinforced by her use of the ‘birth plan’ as the source of information sharing for the midwives in her story. Again, the birth plan[11] has significance to the story, as it is the means by which women can communicate their wishes for their birth experience to their midwives. Where there is content that is more unusual in the birth plan, there is more scope for the midwives to feel challenged and for this to feature heavily in constructions of that particular woman’s identity. P1 states:

> *a woman had on her birth plan that she only ever-*
> *that she only wanted her baby auscultated*
> *by the Pinard [hovers hand over Pinard] and all the midwives*
> *were like [raises hands with Doppler in one and raises eyes]*

[10] This is an anaesthetic procedure that removes the sensation of pain, but also the ability to walk. Necessitating support and intervention that is contradictory to the ethos of the birth centre.
[11] On its NHS Scotland Inform Website NHS Scotland describe the birth plan to women as follows: Your midwife will encourage you to make a birth plan. This enables you to consider your choices and what you would like to happen during the birth (NHS Inform, 2021)

oh I'm not going in there (lines 87-91)

As the audience I offer P1 encouragement to continue with the story, my non-verbal cues and my reflection of her words are the devices that I employ to demonstrate my interest. I offer an ambiguous response: '*right*' to her emphatic telling that the Pinard was *never ever* seen being used in the hospital, had I responded differently, she may have chosen not to go on. Bamberg and Georgakopoulou (2008, p.13) ask that the analyst considers here whether the story implicates the teller in any way, and offer Schiffrin's (1990) perspective that detachment from the story serves to inoculate '*the interactional implication of any personal involvement – as much as this is possible – by mobilizing the self-lamination that stories afford'.* Here P1 is able to tell the story with the intention of not affiliating herself too strongly with any of the available positions, for example as being part of the band of cynical midwives. P1 almost achieves this, but by presenting herself as animator of key aspects of the tale and implementing the words and actions in the way that she does, the discourses within which her identities are being constructed begin to emerge. My responses encourage P1 to continue telling the tale. My laughter (line 92) and my exclamation *wow! (line 99)* further this, position her as someone who has something of interest to share and encourage her to share it with me. In doing so P1 is proposing that we have a mutual interest in the peculiarities of practice that only we have insight into, and which identify us as 'midwives'.

The story that arises is an answer to my question *these things here, do you use these things?* As Bamberg and Georgakopoulou (2008, p.11) suggest, 'the

question is so framed as to project attributes' and in answering my question P1 offers a story that enables her to discuss the use of the Pinard and to project the attributes of *the midwives*. Although, as animator, she chooses not to give voice to the woman or to herself, instead it is the midwives that we hear. In response to my question regarding the use of the Pinard in the hospital (line 83), P1 could have chosen just to say no, but she offers a story, thereby presenting something more personal in relation to the topic being discussed giving a 'more personal approach to the topic under discussion' (Bamberg and Georgakopoulou, 2008, p.12). As the audience I reanimate one of her previous statements about *not going into that room*, giving further voice to the midwives and reinforcing my interest in her story. Referring to Antaki (1994), Bamberg and Georgakopoulou (2008, p.12) discuss the ways in which speakers will 'exploit different aspects of talk in order to mitigate, disarm or equally flaunt their accountability, that is, their normative responsibility for and commitment to what is being said and done.' The story itself affords P1 the opportunity to navigate, albeit tentatively, her accountability vis-a-vis the discourses of midwifery, choice, woman-centred care, risk, professional practice and medical intervention the features of which are discussed in Level 3.

'I' can do midwifery

The latter part of the story is a tale of transition, as P1 answers my question regarding the use of learning about abdominal palpation. She feels was a useful thing to do as she discusses going through the *systematic approach (line 112,115 Figure 25)* to this *because obviously there is a systematic process*.

Figure 25 - 'palpates 'without touching model

As yet, she still has not touched the model, but as she tells me about her process and how she *always comes in at the fundus (line 137)* she touches it for the first time.

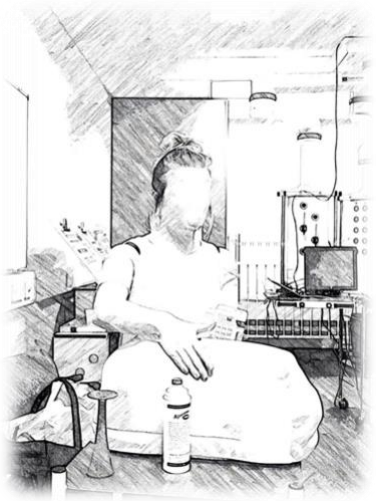


Figure 26 - touches model and 'palpates'

P1 demonstrates to me that she knows how to do palpation *and then support with the other hand (line 141 Figure 26)*, and is showing me as well as telling me that she understands how to 'do' midwifery. As a beginning student, she

tells me that she eschewed accountability for her practice and as she holds her 'self' she states:

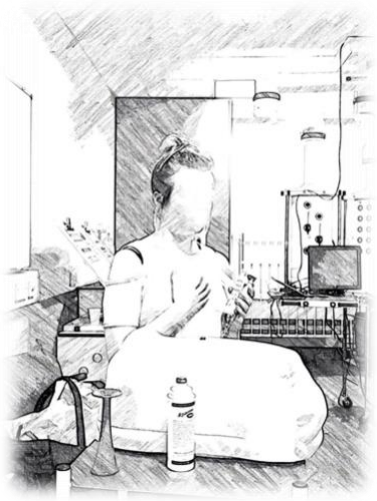


Figure 27 - touches 'I'

I never wanted to say to the woman oh this is your baby's back (line 153 Figure 27) just in case her mentor contradicts her in front of the woman, and as her confidence has increased she validates this transition for me with the following:

> *you can see with the change in your mentor*
> *where she's quite happy as well+ unless you-*
> *I think you see with your case-loading*
> *my mentor was quite relaxed and happy*
> *that if I had a concern or I didn't know what this was that I was*
> *that I was going to say I'm not sure*
> *you+ I felt a lot more confident to say*
> *actually this is the way that your baby's lying (lines 163-171)*

P1 suggests her mentor has changed and is now *quite happy as well*+, she starts to tell me something *unless you- (line 165)* but changes her mind and the direction of the story. It would be interesting to know what might have come next, *unless you what*? should possibly have been my next question. By discussing case-loading[12] P1 is telling me that her mentor trusts her to give care without supervision and communicate back any areas of concern. Having started the second last line with *you*+, P1 pauses and moves to *I felt,* affirming her conviction that she is confident to share her findings with the women in her care. P1 clarifies in a short sentence that she is now competent, trustworthy and capable of autonomous practice.

Positioning Level 3 - who am I in all this?

This level addresses the means by which P1 positions a sense of self/identity in relation to the dominant discourses that unfold through the telling of the story. Bamberg and Georgakopoulou (2008, p.13) propose that this level explores how participants make the dominant discourses 'relevant to the interaction in the here and now' and establish themselves as particular kinds of people. The ways in which P1 positions herself in relation to these discourses and whether she pulls towards/away or is resistant/compliant with them is also central to this aspect of the analysis.

Initially, P1 highlights her position regarding the discourses of education and practice *I think like you think you're never going to be able to do it but once you get out into practice it's completely different (lines 12,13)*. Her description of

[12] This is a requirement of SPRME. Students follow the woman through the entire episode of pregnancy and birth and towards the end of the programme can give care without direct supervision. This can take place in any environment that the woman would usually encounter.

learning about abdominal palpation shifts from it feeling difficult in the university setting to not being *the same thing at all (line 14)* in practice. P1 privileges the experience of *practice* as the site for meaningful learning over the university at this stage. For P1 practice is 'other' to the university and is represented in this instance as a totality, rather than a specific location. Practice, however, comes with additional demands.

In response to my question regarding how it felt to learn about abdominal palpation and my leading question *did it feel exciting? (line17)* P1 agrees that it was, although she quickly moves onto it being *quite a big responsibility (line 20)*. Here P1 references the key term *responsibility* that arises in the discourses of midwifery policy, education and practice albeit in slightly different ways. In policy, for example, the international definition of a midwife recognises the midwife as a 'responsible and accountable professional', here it is the essential 'character' of the midwife that is required to be responsible (NMC, 2009, p.4). Programmes of education 'must be designed' so that on registration students 'can assume full responsibility and accountability for their practice as midwives' (NMC, 2009, p.5). 'Responsibility' in this sense has a more ominous tone and reflects the statutory and regulatory language used by the NMC. In this context, responsibility and accountability are devolved from the many complex features of practice that shape P1's construction of this. The managerial discourses of local and national NHS policy create a dual tension in respect of practitioners having to be accountable to both employer and professional body, the priorities for whom are often in apposition. Finally and importantly, P1 has to navigate the very local and idiosyncratic discourses of 'responsible' practice that arise at the level of the 'mentor'. Oftentimes this is more contingent on personality than

performance (Passmore and Chenery-Morris, 2014), with the former being more difficult to enhance than the latter.

Reflecting the discourses of practice, P1 states if a baby is in a breech presentation and she does not pick this up it can be *quite a big thing.* Here P1's understanding of her responsibilities as regards breech birth arise in the discourses of medico-science and risk. In 2000 a study published in the internationally recognised obstetric journal 'The Lancet' entitled 'The Term Breech Trial' (Hannah *et al.*, 2000) impacted the management of breech birth on a global scale, to the extent that 'on most delivery wards, the expertise required to deliver breech babies vaginally has virtually disappeared' (Glezerman, 2012, p.159). Despite subsequent condemnation of the trial because of its design, methods and conclusions, the influence it had on midwifery and obstetric practice prevails. For P1, her responsibility is to *pick up* the breech presentation, because as Glezerman (ibid, p. 160) furthers in rather stark and authoritative obstetric parlance:

> there are, and always will be, situations when a parturient arrives with breech presentation at the delivery ward and a caesarean section (CS) is not an option due to medical reasons, availability of facilities, very advanced labor or patients' refusal to have surgery, or the attending obstetrician has not been sufficiently trained in assisted VBD. Of course, an individual should not perform a procedure for which he/she is not sufficiently trained, but there are circumstances where a physician may have no other choice than to deliver a breech baby vaginally. Thus, how safe is such a procedure for mother and infant?

Despite there being no mention of a midwife in the statement above, the words *obstetrician* and *physician* could reasonably be replaced with *midwife* in the United Kingdom. In her short statement *quite a big thing,* P1 unwittingly raises the complex and challenging nature of her emerging identity in respect of what she is responsible and accountable for when providing care.

Despite some midwifery experts proposing that breech birth should be considered an 'unusual normal' (Walker, 2012, p.18). The most recent publication of a key midwifery text places breech in a section entitled 'Women and babies with complex needs' and uses the Term Breech Trial as its first citation (Macdonald and Johnson, 2017). Here the discourses of midwifery echo those of medicine and frame this aspect of midwifery practice as risk-laden, about which P1 seems cautiously and possibly superficially aware.

Following this P1 immediately moves away from this more difficult terrain and adopts a lighter tone. She *just really* likes abdominal palpation *when the babies kick out at you and things (line 26)* and with this her direction shifts towards the relational aspects of the discourses of pregnancy and midwifery. P1 understands that there is a diagnostic purpose to the acquisition of the skill but wants me to know that she enjoys this connection with the women and her fetus. The use of *babies* rather than *fetus* is a common feature of the discourses of pregnancy and midwifery practice and does not reflect the terminology of policy or educational discourses, where a fetus is not a baby until it is born.

My question regarding the Doppler and the Pinard open up a discussion situated in the discourses of practice learning and 'mentorship'. P1 constructs

both verbally and visually that she uses the Doppler *a lot more (line 49)* because it is what her mentors do. As such, it is the discursive practices of her mentors in the clinical environment that shape the ways in which P1 identifies with both objects. P1 describes her mentor as *good* as she *always gets the Pinard out (line 59)* and goes over it *because obviously it is one of our competencies (line 61),* thereby giving voice to the requirements of the educational and policy discourses. Momentarily, it seems that P1 understands the imperative for auscultation with the Pinard, but P1 then goes on to say that she does not use it more *because the mum cannot hear it.* While it is true that the mum cannot hear it, P1 fails to recognise the supposed 'fail-safe' rationale regarding the use of this technology. This imperative is articulated in key midwifery discourses (Macdonald and Johnson, 2017, p.527) for example:

> Ideally, the midwife should use the Pinard, and then the electronic monitor, as the means of monitoring the heartbeat are different, and the former is more likely to identify a true fetal heartbeat (Gibb and Arulkumaran 1997).

Interestingly, the midwifery text cites an obstetric text entitled 'Fetal Monitoring in Practice' as the evidence base for the use of the Pinard. Rather than being for the purpose of identifying 'a true heartbeat', P1's understanding is that the Pinard is necessary because she might run out of batteries at a home birth and not be able to use the Doppler. The Pinard is discussed by her *community mentor* who describes using it in the context of a community environment i.e. *home birth* and situates its use as extraneous to the hospital. P1 has *never ever seen one being used in the hospital*, this is interesting in terms of discourses

and developing professional identity as there is a degree of manoeuvring between discourses; here P1 is suggesting that she does what her mentor does i.e. uses the sonic aid more, pulling her towards a more medicalised, risk-averse set of practices.

In the context of this exchange, P1 constructs herself as a caring practitioner who is helping the *mum* because it is *a lot nicer for her* to be able to hear the fetal heart. Here she makes assumptions about what she thinks the experience of this practice is for the woman. While this notion is undoubtedly true for some women, the statement also positions P1 amidst a set of discourses that relate to professional power and control. In that she is generalising about what is *nice* for women; risk, in that without hearing a heartbeat those involved in the practice can't *relax;* and medicalisation in that the use of the sonic aid and the sound of the fetal heart is privileged over any other possible interaction or event.

There is also an undercurrent of tension regarding her own responsibility and accountability that is presented in the statement I think it's nearly *one of the nicest things about their antenatal appointment+ is being able to relax about when they hear the heartbeat*. Although she does not specify to whom she is referring, implied is the suggestion that P1 is also able to relax when she knows the woman has heard the fetal heart. What is unsaid in this exchange is how stressful it is when the fetal heart cannot be heard. The discourses of risk and litigation permeate midwifery practice and lay discourses of pregnancy. However, these discourses are imbued with the positive impact that techno-science has had on pregnancy outcomes. As such, the discovery of fetal

demise as an aspect of auscultation is not a possibility that is commonly referred to or discussed with women in the practice setting (Warland and Glover, 2015). More nuanced aspects of the underpinning discourses of the Pinard and the Doppler play out in the concurrent gestures that P1 makes all the while. Her keen grip of the Doppler and hesitancy with the Pinard arguably enact her affiliation with the former. As she does this, she does evaluate that in order to be more comfortable with the Pinard she needs more practice. Here the discourses of practice override those of education, and when I ask P1 if the Pinard is used in the hospital she illustrates this with the example presented below.

Rather than discuss *the hospital* P1 introduces another practice environment, the Birth Centre. Here P1 uses totems for the discourses of 'normal/physiological' birth – the *birth centre* and the *birth plan*. The birth centre has previously been mentioned, but here it is discursively constructed as a 'type' of environment that some 'types' of women access. The birth plan, which women are advised to complete is proposed in midwifery and pregnancy discourses as a means to give control of the birth experience to women (Welsh and Symon, 2014). Although it can quickly become a site of derision and ridicule if it does not align with the cultural expectations of that environment, or of the discursive practices of those individuals involved. P1 tells me that *all the midwives were like <u>oh</u> I'm not going in the*re, thereby positioning the midwives as resistant to the woman who has exercised her right to 'choose'.

Ironically, the birth centre is precisely the environment where one would expect to see a birth plan and a Pinard being used effectively. In constructing her

narrative, the way that she does P1 is using the story to suggest that if midwives will not support it there, where will they? P1 articulates the contested nature of practice and is reinforcing the ways in which these discourses inhibit her ability to participate in the use of the Pinard. P1 concludes this part with, *it's not a skill they keep up to date either*+. Not only is all hope lost for the preservation of the use of the Pinard as a midwifery practice, but her challenge is also tied into time and resource constraints imposed by CPD and managerial aspects of the organisation.

When I ask if the woman's wishes were carried out, she says *one of the more senior midwives went in and done it for her yeah+ but everyone was a bit like [shakes head] I'm not having her*. Here the woman becomes a site of professional resistance by the midwives, and possibly P1, for not conforming to what their expectations of what her 'choices' should be. The rhetoric of women's choice in childbirth is usually questioned in the light of the discourses of medicalisation, paternalism and patriarchy, not in the context of those who are meant to be with-woman, the mid-wives.

Having told this story, my next question moves P1 back to what she thinks about learning to do abdominal palpation in the SCSC as part of her earlier experiences in the university. She explicates in the language of midwifery, constructing herself as confident, competent and experienced in the routines of practice *I always come in at the fundus* and *obviously there is a systematic process.* This is interspersed with her recollections of being naïve, *you just say*+ *I just always said to my mentor*+ *I have no clue*. The statement is initially prefixed with *you just say*- her change of tense at this point to *I just always said*

immediately reframes the statement in the past tense, indicating that she wants me to understand this as something she no longer has to do. Without the change in direction, the statement could have been *I just say I have no clue,* probably not what she wants me to think at this stage in her programme.

Her final analysis relates to her being accountable for her clinical judgements and communicating these to women, as in *at the start I never wanted to say to the women.* As she does this, she qualifies her confidence in relation to determining the position of the fetus and states that she *feels a lot more confident now with it.* This is reinforced with her telling me that *you can see with the change in your mentor,* signalling to me that her mentor sees this change in her competence too. P1 brings in a number of discourses to reinforce aspects of confidence and competence, her *relaxed and happy* mentor validates her position by supporting her to *caseload*. This suggests that P1 is trusted enough to have been allowed to practice without the immediate supervision of her mentor. This could mean that she has gone into any practice environment and provided care in the same way a registered midwife would. She tells me she is now happy to tell women *that's all normal+ that's all good*, albeit with the caveat that she would still have her mentor check something she was unsure of. Constructing and performing her stories as she does, P1's identities as a current student midwife and future practising midwife emerge in the discourses she orients towards and those that she pulls away from. As such, she positions herself as responsible, accountable, confident and competent, and to a lesser degree autonomous.

Conclusion

This analysis of P1 is presented as an exemplar of the process of analysis followed for all the participants. Of interest are the different discourses which emerge and how these contrast with the subject positions constructed in the SPRME. P1 provides a useful perspective from which to consider her construction of identity in relation to responsibility and accountability in the context of clinical practice. Her use of language, in particular pronoun grammar, provides insight into how she is able to manoeuvre between different identity categories as her student self and as a part of the subject group 'midwives'; both of which are positioned as 'other' to women. The Pinard and the Doppler as refractive devices open up the contested spaces within the discourses of theory and practice, providing a useful lens to bring the 'mentor' into view. The discourses of education arise in relation to confident and competent identities. These are positioned in relation to the material objects of the Pinard and Doppler and also provide a pivot from which to construct and perform personal growth and autonomy. Gesture as evidence of 'contradictory interpellation' (Fairclough, 1992, p.90) into certain discourses emerges as a strong analytical feature of the chapter, and is significant as it highlights where dissonance creates the conditions for transformation in practice.

Chapter 7 - Who am I in all this? A corpus of instances

Introduction

In the previous chapter I set out at length an exemplar of the process for small story and micro-drama analysis. This process was followed for each of the participants, but in order to prevent repetition, the results of these analyses are set out in this chapter in a shortened and condensed form. This chapter therefore presents a corpus of instances drawn from the participants.

Having conducted small story analysis for all participants as shown in the previous chapter, a number of key aspects related to identity emerged across the data. The next stage of the analysis explores these key aspects within five themes: insiders and outsiders; transitions and confidence; competence; responsibility and accountability; and being woman/midwife. Being immersed in the data in an audio *and* visual capacity was particularly significant and important to this. I was then able to revisit the policy analysis and make connections between the two data sets.

The data from each of themes are presented in ‘frames’ which verbally and visually illustrate different facets of identity construction. I do this with the understanding that the framing of these ‘selves’ captures only an interpretation of the participant at that moment in their dramaturgical and compositional timeline. Presented are the tensions, conflicts and contradictions that arise when the subject positions of policy and persons come together as ‘midwifery

practice' in the small stories and micro-dramas of the participants. Critical to this, and to the thesis as a whole, is that as material objects the Pinard and the Doppler play a fundamental role in explicating the visual construction and performance of professional selves. As such, I aim to provide important insights into the experience of becoming a midwife and the positions that are taken up or resisted by the student midwives in their emergent professional identities. In Chapter 6, Frames 1 to 5 are presented as a gestural sequence, relative to the narrative of P1. In this chapter, each frame serves to illustrate a key moment in the construction of professional identity across the participants data.

Theme 1- Insiders and outsiders – *who am 'I' in all this?*

The frames below all relate to the responses to my question regarding the use of the Pinard and the Doppler: *can you tell me do you use those things when you are out in practice?* In response to my question, what follows from all the participants is what Georgakopoulou (2015, p.60) describes as 'non- or multi-linear unfolding events'. In other words, these are stories that move in and out of more than one scene. Moreover, they enable the teller to move in and out of more than one subject position as the stories continue.

The first theme which emerged from the participant data concerns the use of pronoun grammar and the construction and performance of the self. Fairclough (1992, p.64) presents this dimension of grammar as 'transitivity' and explains it has an interpersonal function which understands how social identities are 'set up in discourse' and 'how social relationships between discourse participants are enacted and negotiated'. The interpretation of the NMC's 'essential midwife' emerges from the narratives of the participants as they tell of the challenges

faced when trying to occupy this construction. For the participants, ‘indexing’ (Bucholtz and Hall, 2005 p.593) their identities using pronoun grammar is a prominent feature of their narratives and surfaces in their responses to my questions asking about the use of the Pinard and the Doppler. These articulations and disarticulations using pronouns such as *I*, *we* and *they* are the focus for analysis of this theme. Frame 6 presents the movement in and out of subject positions using ‘I’, Frame 7 considers developing autonomy and the positioning of the self in relation to mentorship, and Frame 8 explores ‘we’ and compliance with professional requirements.

Table 3 - Theme 1 - Insiders and outsiders - frames for analysis

P2	**P10**	**P12**
Moving in and out of the subject position 'midwife' - *I, we* and *them*	Developing autonomy – positioning the self *(I)* in relation to mentorship	Positioning within the profession – *we* and compliance with professional requirements
 *Frame 6 - picks up Pinard, smiles and looks in one end*	 *Frame 7 - holds Pinard upside down*	 *Frame 8 - holds Pinard and Doppler*
in community I would say we++ I have my own one++ I've not seen one- I've never seen them use one in community++ in the hospital they are in+ the area I am in+ they are in the drawers of all the CTG machines they are rarely used+ I've only+ there's only one midwife that I've regularly seen use them and I've never seen them use one in the community++ I use+ like I've got my own one	*no+ I have a Pinard+ I've got two+ but I've never used one in practice++ and I brought it up with my mentor initially and she-she sort of poopooed it a bit em I really like my mentor+ that's not a criticism but that's what she did and then as my confidence grew [passes the Pinard from her left to right hand, holds it correctly] I said to her I would actually really like to use a Pinard and she kind of oh yes yes++ turns out she is a bit sort of frightened of them I think*	*i wouldn't say- we very rarely use the Pinard and I think we only ever used the Pinard because it's a competency not for any other reason em and I've only actually ever used it in the hospital I've never used it in the community*

Frame 6 - Moving in and out of 'midwife' positions - *I, we* and *them*

Frame 6 presents P2, a final year student who through her construction of the Pinard positions herself as shifting between her identities as part of the category group 'midwives' and her developing autonomous professional self. When asked if she uses the Doppler and the Pinard, P2 constructs the Doppler as part of something that is accomplished as a *we* - *yeah we definitely use*

these all the time+ every appointment we are using these. Following this (Frame 1) P2 puts down the Doppler, picks up the Pinard, smiles at it and then smiles at me and says *in community I would say we++ I have my own one*. As she handles and looks at the Pinard, it disrupts the direction her story takes, and she shifts from *we* to *I*. This shift instantiates P2's position from her earlier first-person plural *we* as working with her mentor with the Doppler, to the first-person singular *I* and working on her own with the Pinard. Here the Pinard becomes a device through which P2 constructs *and* performs her developing professional identity. Her handling of the Pinard 'talks' competence in the 'style' of midwifery (Bucholtz and Hall, 2005 p.585), is suggestive of proficiency and immediately interpellates her into the discourses of this 'type' of midwifery practice. This despite her concomitant narrative somewhat acerbically constructing it as a character that is absent in practice: *they are in all the drawers of the CTG machines they are rarely used.* In doing she 'uses the familiar ploy of positioning oneself in relation to the "other" who is generally to be found wanting' (Watson and Drew, 2017, p.326). Here P2 is able to articulate the significance of *them* as 'midwives' and their use of the Pinard as 'other' to her and her developing identity.

P2's construction of the community and hospital enable her to take an evaluative stance and position *them* as 'midwives' and *I* as the 'user of the Pinard'. Even here P2 is able to disarticulate the experience and further evidence her knowledge and understanding of the vagaries of professional practice; she remediates her presentation of a generic *the hospital* to *the area I am in*. This momentary modification acknowledges her understanding that this construction is central to *her* experience in *this* hospital and may not be

reflected elsewhere. Having used *we, I* and *them* to position the Pinard, P2 then uses the passive voice to describe the Pinards in the drawer *they are rarely used*. This enables her to avoid acknowledging who they are rarely used by and constructs her position as a student midwife who is passive rather than active in shaping this experience. There is *only one midwife* that she has regularly seen use the Pinard, here P2 graphically constructs the Pinard as not widely used and further explicates the challenges of professional practice. Despite this, P2 suggests she has created her own opportunities to practice auscultation with the Pinard *I use+ like I've got my own one*. In doing so she strengthens the significance of the Pinard in the construction and performance of her developing autonomous midwifery self.

P2's identification with the Pinard alludes to her position as understanding what she perceives to arise in the discourses of 'good' midwifery practice and the responsibility and accountability that this involves. The Pinard as a symbol of the 'craft' of midwifery practice is prevalent in both formal and informal midwifery discourses and is woven through the stories of all the participants. Although women are positioned as the passive recipients of these processes and are seemingly not made aware of the 'good' that the Pinard is implicated in. In the taleworld (Bamberg and Georgakopoulou 2008, p. 9) P2 goes on to describe how not *all midwives have got time for you to use it*. P2 positions herself as *you* and therefore as student 'other' to the midwives. In describing it thus, she positions the midwives as busy, somewhat inaccessible and not having the same priorities as herself. Through the concept of time, P2 oscillates between her recently constructed autonomous identity and her student self. A

self that is desirous of performing the skill but is constrained by the limitations imposed by the midwives; one of which she is not.

Concluding the story, P2 reverts to *we* as in *we do still use these*+ (the Pinard). The *we* that is figured here is more ambiguous and is indicative of a discrete group to which P2 belongs. It is reinforced with *but not very many other people do* and followed by her evaluation of the whole process, *I don't mind using them+ I think it's good*. P2 indexes her understanding this is an aspect of practice that is considered by her audience (me) to be 'good' practice and should be part of her repertoire of skills as a developing student midwife.

Frame 7 – Developing autonomy – positioning of the self (*I*) in relation to mentorship

P10, a first-year student uses *I* in her small story to position herself and her developing autonomy in relation to the use of the Pinard and her mentor. P10 responds when she is asked if she uses *these things* as I point to the Pinard and the Doppler. P10 immediately picks up the Pinard at the wrong end and tells me *no+ I have a Pinard+ I've got two+ but I've never used one in practice++,* thereby constructing herself as an inexperienced student midwife, but keen to learn this skill as an aspect of the 'craft' of professional practice. P10 states *and I brought it up with my mentor initially* revealing that she instigated the discussion with her mentor and positioning the value she places on the skill. It is also significant as she is speaking to me, her programme leader, and wants to share her appreciation of the value attached to it. For P10 her position as inferior 'student' is reinforced by the mentor who *sort of poopooed it a bit*. She qualifies for me her perspective on their relationship *I*

really like her that's not a criticism and as she does she passes the Pinard from her left to right hand, holds it correctly and completes the sentence with *then as my confidence grew I said to her I would actually really like to use a Pinard*.

This *I* becomes the point where P10 instantiates her emergent autonomous professional self. Using the first person *I* to position herself as a strong proponent of this practice and *she* as the means to identify her mentor's difference. The Pinard is characterised as an object of desire by P10 and an object of fear by the mentor, revealing the divergent discourses within which constructions of professional identity at that moment sit. Her narrative presents a more tentative framing of the experience in the 'there and then', but in the 'here and now' her fleeting gestures metaphorically illustrate an assertion of confidence in both contexts. Without the visual data, these ephemeral but significant moments of the performance of identity would be lost.

Concluding her story, P10 tells me that as her confidence grew she was able to resolve the situation *so finally what we agreed was+ when I go back next in a couple of weeks' time I'll bring my Pinard with me and well she's- we're going to look at opportunities where I can use it* . P10 then makes the caveat *but she's not comfortable with it*, suggesting that further challenges are in the offing. In summary, P10 uses pronoun grammar to assert her position as a good student (*I)* who understands the value of the Pinard, is able to negotiate opportunities to learn (*we)* and can identify where the problem is *(she).* In doing so she wants me to know that she is resistant to these constructions of professional practice and identifies with the midwifery discourses where the 'type' of midwife who will use a Pinard are to be found.

Frame 8 - Positioning within the profession – *we* and compliance with professional requirements

In contrast in Frame 2, P12 a second-year student positions herself and the practice of using the Pinard as aligned with those of the *we* that includes herself and 'midwives'. She affiliates her *I* with what she thinks *we* as midwives do *I wouldn't say- we very rarely use the Pinard* and is able to express her position as regards what she feels is accepted professional practice. Moving from *I* to *we* removes personal accountability for its use and distributes this into the realm of 'what midwives do'. Like P2, P12 constructs the Pinard as a device that *we very rarely use* and situates her position as belonging to this group and the cultural orthodoxies professed therein. She therefore evidences her interpellation into a set of discourses that reinforce the insignificance of the practice. Stating *we only ever used the Pinard because it's a competency+ not for any other reason* P12 suggests that this is something that is only done by *we* midwives to comply with the professional requirements of the programme. P12 inculcates and orientates both herself and those midwives that she is a part of, towards managerial, regulatory and technicist discourses. This while omitting to acknowledge the purpose of competence in auscultation with the Pinard. Subsequent to the narrative captured in Frame 3, P12 takes an authoritative stance on her preferred technology stating *I prefer the Doppler*. In the context of these material objects her identity is sedimented in the discursive practices of the clinical environments encountered on her programme, with the Pinard not constructed as anything other than a *competency*.

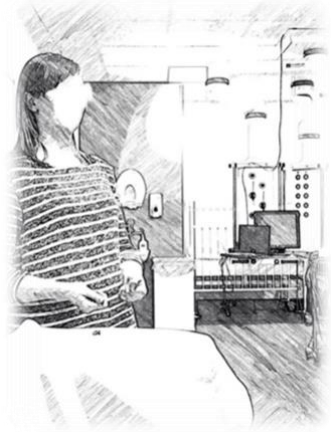
So who am *I* in all this?

Positioning analysis progressively leads to ‘a differentiation of how speakers work up a position as complicit with and/or countering dominant discourses (master narratives)’ (Bamberg, 2005, p.224,225). This stage of analysis moves between the construction of identities from a ‘person-to-world’ and a ‘world-to-person perspective’. In the frames presented, the participants narratives can be seen to employ subtle shifts in pronoun grammar and in doing so positions them and others in and around the discourses symbolised by the Doppler and the Pinard. The somewhat serendipitous nature of this process is discussed by Bucholtz and Hall (2005, p.585) who propose that this use of language and the identities thereby constructed ‘may be in part intentional, in part habitual and less than fully conscious’. Reflecting this, the participants manoeuvre in and out of affiliations with different groupings in seconds as they proceed with both their verbal and visual stories. The SPRME construct a two-dimensional midwife brought forth in the absence of moment-to-moment interaction and action. As the participants use pronoun grammar to construct and perform their midwifery identities, they illustrate far greater complexity in the seemingly simple and mundane competency of using the Pinard and the Doppler to auscultate the fetal heart than the SPRME would suggest.

Theme 2 - Transitions and confidence – *She's a woman she's not a doll*

The theme of transition and developing confidence emerged in response to my interview questions and through the telling and enactment of the acquisition of the midwifery skills of abdominal palpation and auscultation of the fetal heart. The positions taken in respect of these skills and the discourses within which they arise provide the basis for the analysis of frames presented in this theme. Frame 9 provides a narrative of personal growth, Frame 10 explores artifice and constructions of the professional self, and Frame 11 presents myths of professional practice and impossible identities.

Table 4 - Theme 2 - Transitions and confidence - frames for analysis

P3	**P8**	**P15**
Past and present – a narrative of personal growth	Artifice - constructing the face of confidence	Mythical midwives – constructing the impossible
 *Frame 9 - gestures measuring fundal height incorrectly*	 *Frame 10 - gestures holding Doppler*	 *Frame 11 - gestures lateral palpation*
It's the touching the woman's abdomen for the first time and she's a woman+ she's not a doll and everything that comes with it and not looking nervous and+ or even for a long time I didn't know what a symphysis pubis really was I felt like I could measure a woman completely off and it was very= that was the thing that I probably hated the most and gave me the most anxiety was+ what did you get as the fundal height?	*and trying to reassure the woman as well+ you know+ have that face that I'm confident+ [smiles and nods] that I can do this+ not having the face+ I have no idea what we're doing or listening to++ [grimaces]*	*I've still never felt like ears and stuff that everyone- like all the kind of experienced midwives have said that they have+ but em it was quite overwhelming+ but i was quite excited to actually try and see what i felt and if i would kind of match up to the theory of that but there are still some things that still= that i actually don't know what I'm feeling but a lot of that time the midwife comes in and is like i don't know either and i'm like ok that's fine that's reassuring that's ok*

Frame 9 – Past and present – a narrative of personal growth

P3 is a mature student in the final year of her programme. Frame 9 presents her visual and verbal response to my question, which asks whether using the abdominal model in the simulation and clinical skills centre helped to prepare her for clinical practice. What follows is a narrative of personal growth positioned in relation to her early experiences of abdominal palpation.

P3 distils the experience of her simulated practice into one simple statement *It's the touching the woman's abdomen for the first time and she's a woman+ she's not a doll.* This constructs one aspect of her learning as play, and the other as authentic. Part of her authentic experience requires *not looking nervous* and demonstrates that emotional as well as practical skill is involved when working with women. This highlights the significance for her to the events that take place in the clinical area and *everything that comes with it* and contrasts identity positions required in one domain with the other.

P3 uses the past tense to tell me that *for a long time I didn't know what a symphysis pubis really was+ I felt like I could measure a woman completely off*[13] which serves two rhetorical functions, one overt and one less so. The first is the use of the terms *symphysis pubis* and *measure a woman completely off* as rhetorical devices to demonstrate that she speaks our shared 'midwifery' language and positions us as having a discussion together as 'professionals'. The second is interesting in that as she speaks of her prior student self her gestures do not align with her narrative. In doing so, she reveals two things at once; verbally, inexperience and visually, competence. Her gestures demarcate the mysterious *symphysis pubis* and perform her *measuring completely off,* thus raising and resolving the issue for me at once.

Her next statement positions her back in the 'clinic' and position her anxieties around experience in relation to her mentor. Having to confirm her measurement against the measurements that her mentor has already taken *that was the thing that I probably hated the most and gave me the most anxiety*

[13] Fundal height measurement – 'distance between fundus and upper border of symphysis pubis, measured abdominally' (Tiran, 2017, p.89)

was+ what did you get as the fundal height? In the next part of her transcript she accomplishes a sense of rising pressure with the statement that follows *you know? have you got what they got?* As the listener and also as a midwife, this construction leads me to think 'well did you?' Again, an experience shared 'midwife to midwife' that furthers her claim to confidence. The use of the past tense allows P3 the opportunity to contrast for me her prior inexperienced self with the emergent professional midwife she now constructs. Her laughter throughout this part of the story evidences elements of incongruity (Watson, 2015, p.31) i.e. 'imagine feeling this way, how ridiculous' and relief 'thank goodness I don't feel like that anymore' at her transition from this anxiety-ridden former self.

Frame 10 – Artifice and confidence

P8, a mature first-year student beautifully illustrates embodied and enacted aspects of professional identity in relation to using the Pinard and the Doppler with her mentor. Having previously described *trying like a bear* to find a Pinard, P8 characterises herself as tenacious and keen to learn the 'craft' of midwifery practice. In Frame 5, confidence is constructed within the context of professional knowledge and competence. As she describes using the Doppler she constructs a scene where she is trying to learn to hear the fetal heart but has the added pressure of *trying to reassure the woman as well*. Here the discourses of learning and professional practice collide as she constructs her position as that of learner, but also as a health professional who has a responsibility to the woman in her care.

She then articulates and enacts this experience in terms of the embodied interaction required and gestures placing a Doppler on the model *you know+ have that face that I'm confident+ [smiles and nods] that I can do this+ not having the face+ I have no idea what we're doing or listening to++ [grimaces]*. Professional identity therefore requires that *face that I'm confident*, which is metaphorically performed smiling and nodding to an audience. This is in contrast to the face of student identity which has *no idea* and brings forth a grimace to those she envisages being around her. The face of confidence therefore has the potential to inspire or alarm those in her care.

P8 is sharing that she realises the appearance of having a professional *face* is important. In doing so P8 constructs the artifice of the 'enactment' of confidence rather than the possession of confidence as part of this story. All the while letting me know that she is doing this in order to *reassure the woman*. This part of the story concludes with *it's been an experience,* framing these constructions of confidence as significant to her developing sense of identity as a student midwife. Following this, I ask if P8 feels different having been out in practice. P8 evaluates her ability to be confident as a temporal construct in that she tells me she is *not apprehensive at all now* and that she would *be much more confident if we had to do it again*. This serves as a means to 'reassure' me (not the woman) that she no longer has *the face of no idea* previously described. And while she is *obviously not perfect or anything like that+,* she *thinks* that she is *definitely much more confident now+ much more comfortable* and she doesn't *feel apprehensive at all now.*

Her ‘overwording’ of the terms *apprehensive, think* and *confident* as a linguistic feature of her narrative is also seen in aspects the of the policy analysis of the SPRME, and can similarly be viewed as a sign of ‘intense preoccupation pointing to peculiarities in the ideology’ (Fairclough, 1992, p. 193). Rather than the broader political ideologies that Fairclough refers to, this is her personal ideology regarding whom she wants me to think she ‘is’. P8 positions herself in relation to her understanding of the discourses of education and practice and tells me what she thinks I want to hear. The use of *face* as a metaphorical device enables P8 to navigate her uncertainty regarding auscultation as she moves between positions. Goffman (1978, p.30) reminds us that a person ‘in its first meaning is a mask’ adding that in the wearing of such a mask ‘an individual may be taken in by his own act or be cynical about it’. P8 wants me to believe she is confident and not apprehensive, but as she ‘hedges’ her narrative with *think* and *obviously not being perfect,* what emerges is a slightly different story.

Frame 11 - Myths of professional practice and confidence

P15, a second-year student positions her confidence in relation to those ‘artful’ discourses of practice that are the stuff of legend (Frame 6). When discussing the skill of abdominal palpation, P15 gestures performing a lateral palpation[14] and as she does this she tells me *I’ve still never felt like ears and stuff.* This positioning of herself as a novice who has yet to achieve mastery by feeling *ears* is situated beyond the discourses of craft midwifery and arises in mythologised aspects of practice. This creates for P15 a dilemmatic element of

[14] ‘Lateral palpation is carried out to determine the position of the fetal back’ (Macdonald and Johnson, 2017, p. 527)

identity construction, in that without her knowing it sets an unattainable benchmark. If *everyone- like all the kind of experienced midwives have said that they have+,* then P15's successes and her confidence in the future may well be predicated on this understanding. Interestingly, P15 hedges her statement of the midwives with *have said that they have, thereby* constructing the feeling of ears as somewhat unproven on their part.

This leads her into her describing the experience of abdominal palpation on a woman as *quite overwhelming+ but i was quite excited to actually try and see what i felt and if i would kind of match up to the theory of that+,* P15 pauses and changes the direction the narrative takes and in doing so says nothing about whether the theory matched the practice. Following this P15's construction of uncertainty as regards her confidence as a developing professional *there are still some things that still- that I actually don't know what I'm feeling* is justified in relation to her mentor *but a lot of that time the midwife comes in and is like I don't know either and i'm like ok that's fine that's reassuring that's ok*. Quite whether it is reassuring that this account constructs neither as knowing what they are feeling is unresolved in the transcript.

Constructing confidence as a property of midwifery identity – the SPRME

The small stories above illuminate individual struggles with 'confidence' as they are played out against the backdrop of the policies of both education and practice. The student midwives construct their identities in respect of confidence in somewhat messy and unbounded ways. For some, for example P3, her story constructs a prior self who is anxious and scared but her concomitant gestures situate her as having confident practice in the present.

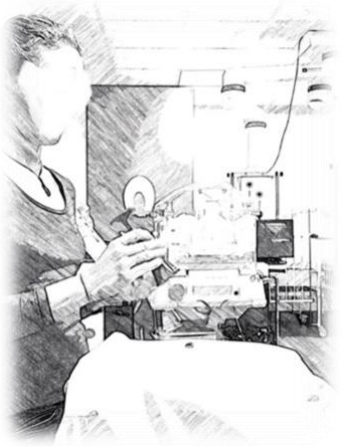
The SPRME (NMC, 2009 p.43,46) construct much more rigid subject positions and stipulate that programmes of education 'must' prepare students to 'be confident in sharing information about common antenatal screening tests' and that 'women can trust/expect a newly registered midwife to be confident in their own role within a multidisciplinary/multi-agency team'. In this instance the modal verbs must and can in the SPRME reinforce the absolute requirement for confidence as a property of midwifery identity. As a further 'essential skill' at the point of registration the SPRME stipulate that a midwife 'inspires confidence, bases decisions on evidence and uses experience to guide decision making'. Not only do newly qualified midwives need to *be* confident they need to inspire it too. The complexities of developing professional confidence are constructed in differing ways by the participants and highlight the disparities between those midwives' identities proposed in the SPRME and those available in learning and practice.

Theme 3 - Competence

The Pinard and the Doppler provide fertile ground for the narrative construction and performance of identity. Amongst myriad other competencies, student midwives must demonstrate competence in 'intermittent auscultation of the fetal heart using a Pinard stethoscope'; however, they are required to demonstrate this several times in several different assessment documents. Through the small stories and the micro-dramas, the following example discusses how three students construct their position as regards their 'competence' in relation to the Pinard and the Doppler in differing ways. Frame 12 illustrates constructing a competent self in the context of time, Frame 13 explores constructions of theory

and practice and developing identities, and Frame 14 considers competence as an aspect of identity relative to mentorship.

Table 5 - Theme 3 - Competence - frames for analysis

P5	**P9**	**P11**
Competence as a property of time	Competence – theory and practice	Being a *hindrance* – compliance and mentorship
 *Frame 12 - gestures holding Pinard in place*	 *Frame 13 - holds Pinard*	 *Frame 14 - holds Pinard on flat of hand*
my community mentor was really good and it was one of the competencies+ so she's like <u>right</u> we will do it and it was on my last day of community placement+ she managed to find it and then held it where it was+ and we swapped so that I could hear it and it was quite good+ but I've never tried it since and i think because it takes a lot longer as well and especially in community you don't really have the time to spend ages looking for it when you can find it quite quickly with the doptone	*so this is+ seeing this+ I have seen one of these out in the community use this [Doppler] all the time and I've used+ there is one of these [Pinard] in the community consulting room and my mentor has one in her bag and I've used it maybe three times in four weeks and I've heard the heartbeat once out of those three times so- but she doesn't- she used it as a kind of oh it's on your list we better do that+ it's not used as standard at all++ that's a point+ did we get to use one of these? I don't think we did+ in uni+ I think someone showed it to us and said this is a Pinard+ and this is what you do with it and we watched a video+*	*we're meant to and I know that [holds Pinard on flat of hand] but it's often difficult in the hospital kind of saying oh well I need to use the Pinard as well because it's so like= i don't know you're just kind of wanting to do what a mentor wants you to do and if they don't say it you don't want to be+ I guess a hindrance but I've used it a couple of times just with the competencies and when I've said oh is it ok if I have a shot but especially if it's a slimmer woman then I know that I'm definitely going to hear it as well*

Frame 12 – Competence as a property of time

The first of these identity constructions emerge in relation to a small story and micro-drama involving a 'good mentor' supporting P5 to try and achieve

competence with the Pinard. P5 at this point is a final year student and is seven months away from qualification and registration as a midwife.

I ask her *do you use those things?* And she tells me that she has used the Pinard and *heard a heartbeat once and that was in first year*. Confident to tell me that she has *never tried it since,* P5 inculcates herself in a position relative to the 'tick box' critique of competency-based learning (Fenwick and Nerland, 2014). In relation to the hearing of *the heartbeat once*, P5 tells me of her *community mentor* who is *really good.* This positions the mentor in relation to those who are 'not really good', therefore, a *really good mentor* is positioned as competent in the use of the Pinard.

From here, P5 tells me *and it was one of the competencies.* As she makes the statement, she gestures writing something with her left hand, rather than listening with the Pinard. With this gesture, P5 constructs *competency* as a signature that her mentor must provide for each competency in her practice learning documentation. Her story evolves into her telling me of the challenges that she faced in trying to hear the fetal heart; how on her on the last day of her placement her mentor is *like right we will do it.* The fact that P5 temporally locates the story on the *last day* of placement gives a sense of importance and urgency in respect of what competencies P5 still needs to do. P5 tells me that her mentor *manages to find it*, which lends a sense of struggle to the task and positions it as complex and challenging for the mentor too. P5 then gestures changing positions with her mentor who *held it where it was+ and we swapped so that I could hear it* which for P5 was *quite good*+. P5 is telling me that her good mentor has helped her achieve the competency, but it is a complex thing

for both of them to achieve. This is despite the story revealing that the mentor has demonstrated competence, not P5.

P5 describes this experience as *quite good but I've never tried it since*, she furthers this and tells me this is *because it takes a lot longer as well and especially in community you don't really have the time to spend ages looking for it when you can find it quite quickly with the doptone*. Here, the pressures of time and space become the pivot around in which the maintenance of competence is articulated. Her use of the pronoun *you* in its plural form, is a linguistic device that detracts from accountability being attributed at an individual level. It also enables P5 to generalise what *you* as a student midwife or midwife have and do not have, in respect of time for being competent. Here P5's *especially in the community you don't really have the time to spend ages* mobilises the discourses of professional practice and professionalism to articulate her position regarding the Pinard. This is reinforced by the end of the statement *when you can find it quite quickly with the doptone, which* gives insight into her emerging identity as a busy and efficient midwife. The conclusion to the small story restates her position as we both respond to the start of my question *so that's the*+, her */way to do it*\ overlaps my */weapon of choice**?* And answers it quite concisely.

Frame 13 – Competence theory and practice

P9's discussion of competence tells of the challenges of professional learning and highlights some of the constraints of the clinical environment in the provision of this. Participant 9 is in the first year of her midwifery programme.

This is her second experience of a university having already completed a previous degree.

The mentor is characterised as using the Pinard because *oh it's on your list* with the list being the practice document that details the competencies required to be achieved for that practice placement. P9 picks up the Pinard and states *so this is+ seeing this+ I have seen one of these out in the community*, this gesture almost anticipates the question that follows as I ask her *do you use these things?* With the Pinard still in her left hand, P9 picks up the Doppler and says *em use this all the time+ [then puts Doppler back down] and I've used- there is one of these [holding Pinard] in the community consulting room*. As she continues to hold the Pinard it mobilises another opportunity to talk about her experience of learning, this time in relation to auscultation with the Pinard in clinical practice. P9's mentor has *one in her bag* that she has *used maybe three times in four weeks* and has *heard the heartbeat once out of those three times so- but she doesn't- she used it as a kind of oh it's on your list we better do that+ it's not used as standard at all*. In stating this P9 positions the Pinard as in a room and in a bag not as an active part of her acquisition of the skill, and her mentor not helpful in enabling P9 to achieve what is on her *list*. As *it is not used as standard at all*, P9 further positions the use of the Pinard as not part of the discourses of her community midwifery experience.

While it seems P9 positions clinical practice as accountable for the lack of opportunity to hear fetal heart, her next statement progresses the failings of the university as more significant *that's a point+ did we get to use one of these? I don't think we did+ in uni+ I think someone showed it to us and said this is a*

Pinard+ and this is what you do with it and we watched a video+. P9 raises the issue of not having been prepared for practice adequately by the university and is holding me to account in my role as her programme leader. She goes on to make a recommendation as to how learning in respect of this could be improved and makes it clear that hers was an unsatisfactory experience. P9 then clarifies that in relation to the Doppler *actually we didn't get to use these in uni either+ I mean I guess you can't teach us everything before we go out but em they are fairly straightforward*. In both instances my response does not acknowledge the challenge and moves the discussion on, somewhat suggestive of my own discomfort with this robust critique of her learning.

Frame 14 – Being a *hindrance* – compliance and mentorship

P11 tells me that she knows that she is *meant to* use the Pinard, but *it's often difficult in the hospital kind of saying oh well I need to use the Pinard as well* (as well as the Doppler) and constructs the hospital as a place where asserting your requirements for competence is a challenge. This positions the skill as something that is the responsibility of the student to achieve, rather than as a shared objective with her mentor. Long problematic (Chenery-Morris, 2015; Fisher *et al.*, 2017), the grading of midwifery practice can further the imbalance in power between student and mentor. As such, P11 constructs her experience of trying to use the Pinard in the context of compliance and *just kind of wanting to do what a mentor wants you to do.* This with the intention of not wanting to be *a hindrance* in the clinical setting. P11 wants me to understand that despite this she is resourceful and pragmatic and has been able to use it when she has said *oh is it ok if I have a shot.* Moreover, she is able to share her midwifery

knowledge of the conditions that will facilitate this *especially if it's a slimmer woman then I know that I'm definitely going to hear it as well.* P11's tale is somewhat of a redemption narrative; in that she constructs for me a scenario where despite feeling a burden she has managed to overcome this and make opportunities for her learning. All the while with the Pinard balanced on the flat of her hand, distinctly lacking purpose.

Being competent

The participants all mitigate accountability as to the subject positions that they can occupy regarding 'competence' on account of their discursive constructions of mentorship and the university and practice environments. Competence as a concept is explored in the SPRME in Chapter 5, with the conclusion that it is a condition of midwifery identity but is poorly defined and constructed in the document. Here, competence is constructed by the students as being dependant on the priorities of both individuals and organisations.

Theme 4 - Responsibility and accountability – *actually using that is quite a scary thing*

SPRME states that 'education programmes must be designed to prepare students to practise safely and effectively so that, on registration, they can assume full responsibility and accountability for their practice as midwives' (NMC, 2009 p.5). This is no small task and acknowledgement of this is articulated in various ways by the participants in their small stories and micro-dramas.

For some of the participants their identification with being responsible and accountable is overt, others frame it more covertly. The frames used illustrate how participants constructed and performed aspects of responsibility and accountability in the context of both the academic and clinical settings. Frame 15 considers techno-science and the role of surveillance in developing identities, Frame 16 explores interpersonal constructions of professional selves, and Frame 17 highlights the impact responsibility and accountability have on 'being' a midwife.

Table 6 - Theme 4 - Responsibility and accountability

P3	**P14**	**P10**
Material selves	Midwife to midwife	Materiality and me
 *Frame 15 - gestures holding mobile phone and pressing buttons*	 *Frame 16 - points to Doppler*	 *Frame 17 - gestures trying to find fetal heart with Doppler*
and then you could sometimes bring in other elements (…) clinics+ can I record this? my husband's not here and you just think+ [laughter] (…) the pressure's on+ and you're like+ can you wait till I get it? so that there's less pressure+ but they're ready and waiting	*whereas obviously- and obviously with this they can hear it instantaneously but obviously my concern as someone who has obviously been to the triage department now in second year is that if you do have a woman coming in who has got reduced fetal movements or had any kind of physical trauma to the stomach then actually using that [doppler] is quite a scary thing and there have been times where I would rather use that+ rather use a Pinard because- because I think+ what if this is that time when actually I can't find- and if I am on my own+ what if I can't find a heartbeat*	*yeah so I've used these a lot+ [Doppler] it's- they seem to use it kind of em all the time not really when it's almost necessary like quite early on they've used it+ em sometimes I don't like using them because you can't find it straight away and it's a bit stressful em I quite like enjoying it with the woman because it's really nice to+ like they really want to hear this and they get a lot of joy out of it and a lot of relief so it's quite nice sharing that moment it feels quite privileged to be a part of that*

Frame 15 – Material selves

Participant 3 frames her burgeoning responsibility and accountability in the context of technological surveillance and feeling *pressure* in relation to auscultation of the fetal heart with the Doppler. P3 discusses complications that

might emerge in the moment of auscultation and tells me that the woman might ask *can I record this? my husband's not here.* My response *oh really?* is very much surprise and intrigue, having never considered the extent to which mobile technology has permeated and extended routine aspects of care.

The seemingly innocuous request by the woman has implications for the student and the midwife should the fetal heart not be heard for any reason. Implications that will be apparent to the student and the midwife, but only to the woman should there be a problem. A problem which could then potentially be recorded on the device and presented as 'evidence' should it be required. P3 uses the term *pressure* to describe the moments between the imagined woman in the story's request and her being able to *get it.* P3 then mimes the woman holding her mobile phone pressing buttons and says *but they're ready and waiting,* placing the responsibility for the woman being able to communicate this significant life event to her husband on P3's shoulders. P3 positions herself in these complex discourses in order that I understand that these practices have presented challenges that go beyond what is taken-for-granted about auscultation. Technological interventions extend the positions that P3 is expected to occupy from those which occupy confidential and private spaces to those which are public facing and highly visible. Like Pinard and the Doppler, this construction affords the mobile phone significant agency in respect of the positions that P3 is required to take. Through this she verbalises and visualises her vulnerability in respect of her accountability and responsibility.

Frame 16 – Midwife to midwife

While for some of the participants the Doppler is the *way to do it* for others, it presents a more complex challenge to professional identity and practice. Responsibility and accountability are discussed by P14 in the context of the Pinard and the Doppler and the potential situation of not being able to hear a fetal heart because of a maternal or fetal complication. P14 is a mature student who is in the second year of her programme. Her use of the term *obviously* in the first four lines of this section of the transcript gives an indication of how she positions herself in relation to me in the context of the story, and tells me we are talking 'midwife to midwife'. Her language interpellates her in the discourses of midwifery practice and reinforce her familiarity with the *triage*[15] environment. P14 positions herself as knowledgeable and able to interpret the significance of the process in the context of a potential adverse scenario. In her story, P14 raises the issue of being accountable for the sharing of difficult information relating to fetal demise when using the Doppler *if you do have a woman coming in who has got reduced fetal movements or had any kind of physical trauma to the stomach then actually using that [Doppler] is quite a scary thing.* P14 positions herself in relation to the discourses of responsibility and accountability for finding and sharing the sounds of the fetal heart. Another participant (P15) constructs this moment beautifully when she says *but <u>they</u> can hear+ if <u>you</u> can't hear a sound if that makes sense?* P14 describes the Doppler as *scary* for precisely this reason, that when there is no heartbeat everyone can hear the silence.

[15] Triage – clinical environment where priority is determined according to need.

P14 constructs the Pinard as being what she would prefer to use in this situation *because I think+ what if this is that time when actually I can't find- and if I am on my own+ what if I can't find a heartbeat* telling me that she thinks the responsibility of accounting for silence might be mitigated by the use of the Pinard. A complex analysis of the properties of both practices emerges in the here and now of her narrative, with P14 subtly positioning herself as a knowledgeable and cautious professional who understands the difficulties of professional practice. When I later ask what stops her from using the Pinard in the situation that she has described, she says *my own self,* articulating a different type of responsibility and accountability in relation to her practice. She closes this small story with *but I think it does tend to be that most women they've seen the sonic aid+ the doppler they would like for you to continue to use that em* and leans towards a discursive construction of women as the agent responsible for determining which processes are employed.

Frame 17 – Technology and me

P10 uses contemporary midwifery discourses to position herself as woman-centred in relation to the practice of auscultation of the fetal heart with the Doppler. Her construction of this process also enables her to identify with the type of midwife who is also evidence-based. P10 makes an evaluative statement about how *they* (midwives) use the doppler *they seem to use it kind of em all the time+ not really when it's almost necessary+ like quite early on they've used it*. P10 hedges her commitment to the statement by using the words 'seem, kind of, not really, like, quite'. If these words are removed, what she says is *they use it all the time+ not when it is necessary+ early on*. The

substance of her statement reveals her knowledge of the proper use of the Doppler and how *they* have misused it. In doing so she reveals that she is competent as regards her knowledge of the Doppler's proper and improper use. Again, this brings to light the contested nature of the discourses arising in the practices surrounding the Pinard and the Doppler.

P10's position as regards using the Doppler focuses on anxiety related to finding the fetal heart follows *sometimes I don't like using them because you can't find it straight away and it's a bit stressful*. As she talks, she enacts moving the doppler from place to place on the abdomen trying to find a fetal heart. This enactment subtly illustrates how pressured the situation can be when a fetal heart is hard to find. Her gesture gives a subtle indication that she is inculcated in the discursive practices which enable experience of this.

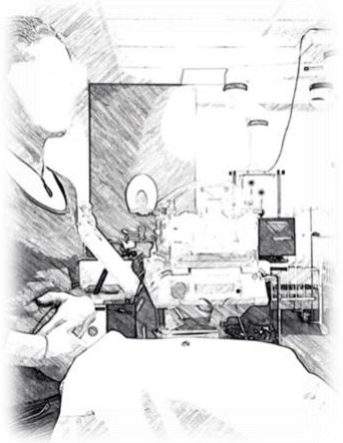
P10 then reframes the doppler from being a source of stress to something that can be enjoyed with the women. Describing how *it's really nice to- like they [gestures to woman] really want to hear this and they get a lot of joy out of it and a lot of relief*. Having just mentioned her own stress in finding the fetal heart with the doppler it is likely that the 'joy' and the 'relief' are not just on the part of the 'women'. Her shift in direction *it's really nice to- like they really want to hear this* suggests that she may have said 'it's really nice to hear it' but recognises that this considers her position rather than that of the women. In doing so P10 furthers to me her position as understanding what women want and how she is able to provide this. P10 goes beyond doing the things of midwifery in her final statement on this topic and expresses to me that she feels sharing that moment is privileged. In doing so, P10 is communicating to me that she is taking nothing

about her identity as a student midwife for granted and she is truly 'woman-centred' and that being 'with woman' is more than just performing tasks.

Theme 5 - Being woman/midwife – embodied selves

The SPRME stipulate that student midwives 'must understand and practise competently' such processes as 'women-centred and holistic care' (NMC 2009, p.6). Here, the modal verb 'must' suggests the degree to which the NMC requires this to be a feature of professional identity. What is not made clear is the meaning of 'woman-centeredness' and 'holism'. As a discursive practice, this situates these meanings as a taken-for-granted aspect of midwifery practice, where the context free 'woman' is at the 'centre' of decision making. Being woman-centred is different to being 'mid-wife/with woman' and also from varying applications of feminist thought in relation to the provision of care. Constructed as it is, being 'woman-centred and holistic' is a rhetorical feature of contemporary midwifery policy and practice discourses. Whereas being 'with-woman' denotes the meaning of the term 'midwife'; representing what Laclau and Mouffe (2015, p.101) contend as a 'discursively constructed subject position, its presumed abstract character in no way anticipates the form of its articulation with other subject positions'. Here, the subject position 'mid-wife' is constructed and performed by the participants in relation to 'other' embodied selves. Frame 18 presents constructions of the woman as a 'challenge' to her professional identity, Frame 19 examines the using her own 'self' as a means to an end in understanding anatomy, and Frame 20 highlights the ways in which the physical attributes of the 'self and other' impact developing professional identity.

Table 7 - Theme 5 - Being woman/midwife - frames for analysis

P14	**P9**	**P14**
Stress testing – gamesmanship and the self	My 'self' as an anatomical model	Flexible selves
 *Frame 18 - holds Pinard*	 *Frame 19 - holds abdomen*	 *Frame 20 - gestures using Pinard*
the first time I tried using this she asked me to do it on a woman whose BMI[16] was greater than 30+ just to see how i would cope i think and I couldn't hear it+ neither could she+ so then we used the doppler	*I'm always measuring a bit differently from my mentor and I think that's because I'm not quite sure where the pubic bone is and if I'm honest it's probably because I'm a bit embarrassed about rummaging around in someone's pants kind of like I'm not really sure so i had to have a feel of my own when I got home and kind of like oh its actually quite a long way below your bikini line so i am wrong+ em and its i mean it's really hard to= it's reassuring that when you are out in community your mentors say you know what this is really hard and it takes a lifetime to get +*	*physically for you as a midwife you would have to be much more flexible with your own body with that [looks at Pinard] em no em maybe ( ) next time I'm in labour ward I'll give it a bash+ but I've never seen any of the midwives using them*

[16] Body mass index (BMI) = weight (kilograms) divided by height (metres) squared – '30 kg/m² or more at booking indicates OBESITY [author emphasis]' (Tiran, 2017, p.28)t

Frame 18 – Stress testing – gamesmanship and the self

In Frame 17, P14 tells a story of a practice-based challenge issued by her mentor. Here, the woman is positioned as being a device through which not only is P14's competence with the Pinard is assessed but also her ability to *cope* in relation to a woman's size. P14 tells me of her first experience of using the Pinard and her mentor asking her *to do it on a woman whose BMI was greater than 30.* P14 uses this example as a means to illustrate that there are times when the Pinard is difficult to use, with her mentor setting the objective *just to see how I would cope I think.* Here P14's positioning of the woman, like that of P11, presents her size as the contingent factor around which the practice of using the Pinard is based. As P14 *couldn't hear it and neither could she (the mentor),* she concludes with *so then we used the Doppler*. This positions the Doppler as the means by which the shape of women can be overcome when the Pinard is unable to be used. P14 situates the 'game' and her competence in this respect as arising in the discourses of obesity and body politics, and also in more subversive aspects of mentorship. P14 highlights her mentor's lack of success to reinforce her own position regarding hers and rhetorically constructs her emergent identity as victor.

Frame 19 – My 'self' as an anatomical model

Unlike the rest of the participants P9 is confident to 'play' with the model before we start the interview. As a first-year student with limited placement experience P9 demonstrates that she is already interpellated in the discourses of midwifery practice without saying a word. Her actions position her as knowledgeable in this respect and inform me that 'I know what I am doing here'. Following my

initial question, we then go on to explore her experiences of learning about abdominal palpation for the first time.

In this part of P9's story pubic bones and mentors are introduced as challenging characters. The former for their mystery *I think that's because I'm not quite sure where the pubic bone is* and the latter because she is *always measuring a bit differently*. As she does this P9 places her hands on her own abdomen and prefigures what is coming next as she goes on to describe the difficulties of the *pubic bone*. 'Someone' as in the woman is introduced as a complicating source of stress for P9 as she states *if I'm honest it's probably because I'm a bit embarrassed about rummaging around in someone's pants*. The nature of midwifery is such that there are multiple opportunities for personal and professional embarrassment and P9 positions herself as the redeeming character who provides the solution to this. In order to address *always measuring a bit differently from my mentor* P9 tells me how she resolves the issue *I had to have a feel of my own when I got home and kind of like oh! it's actually quite a long way below your bikini line*. Despite having had a *pubic bone* all the while, P9 is telling me how her own body now has a practical application in her learning, and also demonstrates her resourcefulness in mitigating this particular issue. This embodied construction is only available to P9 as a gendered experience through the use of her own woman's body in her competence as a student midwife.

P9 is both frank and forthright and she draws from the discourses of midwifery practice to situate our discussion as 'midwives resolving issues together'. Her final comment lends a temporal dimension to her ability to be practised in these

skills, in that her reassuring mentors understand that *this is really hard and takes a lifetime to get*+. Constructing in a moment the professional commitment to lifelong learning required of her student midwife self.

Frame 20 – Flexible selves

P14 brings discusses her own shape and size in relation to providing care for a woman in labour. P14 immediately alludes to the 'type' of woman that she is giving care to in labour. Positioned and enacted as on her feet with *lots of swaying going on* P14 inculcates the woman in her tale in the discourses of 'active birth[17]', which although not constructed as such in midwifery discourses is the opposite of 'passive birth'. P14 sets the scene for another challenge in relation to the practical application of the Pinard in practice and raises another subtle challenge to its use. Although P14 is quite *happy to get down- move around on all fours whatever*+, she would have to be *much more flexible* with her own body to use the Pinard. The Doppler, however, can be used with the swaying woman as the transducer head is attached to a length of flexible cable, thereby keeping birth 'active'. P14 tells me that in order for the Pinard to be used her own body would need to be active, constructing her position in the context of her own health and fitness. The shape of the *swaying* woman then becomes an impediment to practicing with the Pinard.

P14's construction of practice is intelligent and insightful in that it illustrates how that which is perceived to be a 'craft' aspect of midwifery practice is sometimes not practical in that context. All of which resides in her construction of the

[17] 'style of birth preparation and care empowering mother to take active part in labour and decisions needed for her care' (Tiran, 2017, p.4)

practice of auscultation of the fetal heart in labour, interpellating her in the discourses of midwifery and medico-science. Her concluding statement brings the story back to the discussion as regards their use *but I've never seen any of the midwives using them* and situates the practice as being somewhat anachronistic.

Bodies

In contrast to the context-free constructions of being woman-centred in the SPRME, the participants' stories and micro-dramas challenge these concepts of woman-centredness and as such they construct themselves as women providing midwifery care somewhat differently. The women they construct and perform are at times passive, but are also visceral, slim, fleshy and somewhat 'off-centre'. If to be mid-wife is to be with-woman, the ways in which this plays out in the stories and micro-dramas highlights some of the practical constraints that clinical practice imposes on their emergent identities. Again, the discursive construction of the application of the Pinard and the Doppler serve as a means to demonstrate this.

The examples discussed present a contrasting perspective to that of the SPRME where women are constructed as being the passive recipients of care and who take a homogenous form. The physical properties of the student's own bodies and those of the women in their care are not a feature of SPRME but are constructed and performed by some of the students as being implicated in their emergent professional identities.

Chapter conclusions

In this chapter, I used different examples of participant data to present the empirical aspect of the study through the small story and micro-drama analyses. The frames used themes to explore a corpus of instances arising from the participant data. The discourses that the participants positioned themselves within were in many cases the same as those discussed in Chapter 6; however, the positions taken by them were often constructed in contrasting and sometimes oppositional ways. While managerialising and organisational practices were articulated, they were constructed in the informal and local contexts of practice. The discourses of risk brought the responsibilities and accountabilities of clinical practice into view at the same time as stress, anxiety and fear were expressed. The discourses of lifelong learning and professional learning came from the discussion of simulated practice. Theoretical aspects of becoming a midwife were less prominent (but no less sharp where they did occur) in the discussion as regards value, often taking a back seat to the 'hands-on' of practice.

Informal and craft midwifery discourses are used in the context of practice and construct women and care differently to the 'women-centred' discourses of the SPRME. In doing so, the discourses of health and fitness, feminism and body image emerge. 'Good' midwifery arises in the discourses of mentorship and effective learning in clinical practice, alongside the properties of time, productivity and constructions of the environment. Central to many of the stories and enactments of identity were the Pinard and the Doppler; positions on which were situated in the discourses mentioned, but also brought those of

medico/techno-science, autonomy, care and medico-legal construction to the fore.

Chapter 8 - Discussion – constructing and performing identities

Introduction

The title of this thesis *Powers, passages and passengers: the construction and performance of student midwives' professional identities* uses a metaphor which arises in midwifery and obstetric discourses. From the beginning of my doctoral studies I understood, albeit implicitly that these words told a story of sorts. The metaphor 'powers, passages and passengers' uses the language of industry to articulate the mechanism of labour, and in doing so reduces the complex, the known (and sometimes the unknown) to a simple three-stage framework. This thesis is the product of developing my understanding of the metaphor and applying it allegorically to the experiences of the student midwives and their 'frameworks'; with the *powers* as the powers of policy and practice, the *passages* as the environments within which midwifery is experienced and the *passengers* as the students and those who they encounter on their journey. It is applied in the thesis in relation to the construction and performance of midwives' identities, both in the policy analysis and the small stories and micro-dramas of the participants in the empirical part of the study.

In this chapter I discuss the findings from the policy analysis in Chapter 5 and relate this to the empirical findings from Chapters 6 and 7. I revisit the aims of the study, how they have been addressed and propose my contribution to knowledge. In doing so I address my research questions, bringing together the ways in which policy constructs midwives and the ways in which the student

midwives discursively construct themselves and their professional identities. As such, I resolve the questions:

How are student midwives constructed in the discourses of policy, professionalism and learning?

How do student midwives position themselves in relation to these discourses?

In what ways are these positions implicated in the construction and performance of their professional identities and what significance does this have for practice?

In addition, the response to the methodological research question which asks *in what ways can the inclusion of gesture contribute to the development of small story analysis?* is incorporated into this discussion and addresses the ways that visual analysis through the micro-dramas has contributed to and developed small story analysis

Policy constructs midwives

The Standards for pre-registration midwifery education (NMC, 2009) construct 'midwives' in somewhat of a statutory and regulatory vacuum, in that there is no consideration of the idiosyncratic nature of practice. The analysis of the SPRME revealed that 'midwives' are understood primarily as obedient, compliant, confident, competent, skilled, knowledgeable, autonomous, accountable, woman-centred, evidence-based, responsible and deferential. These positions are representative of the 'highly regimented, normative practice' (Fairclough 1992, p.94) of 'code' models of discourse and construct a midwife that is

significantly orientated towards the requirements of the institution. In contrast to the rigid subject positions articulated through SPRME, aspects of midwives' identities that emerge from the small story and micro-drama analysis as 'under construction' and 'in performance' are more tentative and shifting; both conforming to and resisting the 'official' discourses of the standards.

The analysis of the SPRME in Chapter 5 follows Fairclough (1992, p.85) in that it explores discursive practices using a combination of micro and macro analysis. For example, at the micro level, the use of grammatical features such as modality and transitivity enable a close textual analysis. Macro-level analysis uses intertextuality and interdiscursivity in relation to the production, distribution and consumption of the text; with the micro informing the macro and vice-versa. This enables the relationship between micro/macro analysis and social practice to be explored. In much the same way, positioning analysis explores narratives from the micro to the macro level, again with the understanding that they are mutually implicated. Positioning analysis and small story work require an understanding of how to identify and interpret sociocultural linguistic features of textual and visual narratives. The methodology employed in the policy analysis enabled me to identify these features and interpret them using Bamberg and Georgakopoulou's (2008) three-step process.

The empirical data yielded five themes as stated in Chapter 7, and are presented as neither definitive nor conclusive of 'professional identities'. Instead they illustrate significant moments in the construction and performance of identity by the student midwives, and how they articulate and disarticulate with those of the SPRME (NMC, 2009). This discussion brings together the policy

analysis, the positions taken by the students and the discourses within which these arise. It presents language and the construction of the self, the significance of the material to the positions taken and details the discursive construction and performance of these in both the SPRME and the empirical data.

The function of language in the construction of the self

In the SPRME the NMC (2009) use the pronoun ‘we’ to describe themselves. Jørgensen & Phillips (2002) maintain that personification i.e. ‘we’ is suggestive of conversational discourse. As midwives are referred to in the third person this would appear that this conversation being had by the NMC is not with them, but with the wider public or ‘stakeholders’ as they are referred to. This is described by Fairclough as ‘interactional control’ and explains how a relationship is established between the author of a text and the intended audience. The NMC use interactional control to establish its authority regarding the discursive construction of the subject position ‘midwife’ and state it as a matter of fact.

Unlike the SPRME where interactional control is fixed, the narratives of the participants disperse agency with regards to interactional control. In doing so they orientate between different available identity categories relative to the subject position ‘midwife’ and ‘student midwife’. While the SPRME suggest homogeny in this respect, the participants moved in and out of subject positions from moment to moment using pronoun grammar to identify as midwives, students, insiders, outsiders, non-mothers, mothers, mavericks and more. Significant to the surfacing of these positions were the Pinard and the Doppler,

the discussion of which enabled both constructions and performances of the self in the context of learning and midwifery practice.

Materiality and the construction and performance of identity – the power of the Pinard and the Doppler

It is important to acknowledge the significance of 'objects' such as the Pinard and the Doppler in the construction and performance of identity. I view these 'objects' as being enmeshed in 'discursive practices' (Fairclough, 1992, p.73) and therefore acknowledge the material effects that the Pinard and the Doppler have in mobilising similar/different identity positions.

For eight of the sixteen participants, telling me of the purchase of their own Pinard was a feature of their small story and micro-dramas. Making possible the navigation and explication of their positions vis-à-vis the discourses of policy, learning and practice. The Pinard is small, inexpensive, emblematic of good midwifery practice and sits within formal and informal midwifery discourses.

Only one participant, P14, mentions *the framework* (SPRME) and in doing so positions herself as understanding the regulatory requirement to be competent in the use of the Pinard. Her small story draws from her mentor's craft midwifery discourses, which imagine a scene of isolation and technological deprivation. P14 tells me how her mentor has been a midwife in *more rural areas* where it is *absolutely fundamental* that you know how to use the Pinard. In saying that she *completely* agrees, P14 interpellates herself in the same discourse and constructs the practice as a necessary fail-safe for the aftermath of the apocalypse.

Within the literature pertaining to professional identity is the theme of uniform (MacDonald, 1995; Evetts, 2003) as an aspect of professional membership. For these becoming midwives, the Pinard becomes a totem of identification with the uniform of a 'type' of midwife. Here, the students are able to 'purchase' an aspect of their emerging midwifery identity and yet the use of it is thwarted by the conditions of practice. And while the Pinard has become an emblem of craft midwifery discourses, the historical purpose of its use arises in the discourses of biomedicine and techno-science. This inculcates the students in the contested discourses of practice, subsuming for some the desire to use it: P12 *we very rarely use the Pinard,* and for others increasing it: P2 *I've never seen them use one in the community++ I use+ like I've got my own one.*

The use of the Pinard and the Doppler arise in an interplay of complex discourses that have historical, professional and cultural constructions. Having been constructed as 'commonly used' in 1975 (Myles, 1975, p.109), the Pinard emerges in the discourses of the student midwives as tricky, and the Doppler as commonplace. The SPRME constructs the Pinard and the Doppler solely in the context of achieving competence in their use. There is no acknowledgement of the forces that give them agency and implicate them in the performance of identity, such as the complexity of the cultural environment within which knowledge is constructed. Bassett (1996, p.287), in an anthropological discussion of electronic fetal monitoring and medicine, suggests that the process of hearing the fetal heart 'facilitated a closer bond between doctors and the fetus and made the fetus seem within the doctor's reach', similarly this connection is true of the student midwives who somehow feel accountable for the auditory process and its connection to fetal viability. In the same study,

Bassett proposes that the act of listening becomes a means to 'prove fetal health rather than detect fetal distress' (ibid) all of which resonates with the anxieties that arise in the narratives of the participants.

One participant tells me that *obviously at the start+ first couple of times I couldn't find the heartbeat* and as she does so she taps the Doppler that she is holding with her other hand. This gesture inadvertently positions the Doppler as the source of the heartbeat rather than the fetus and succinctly illustrates the ways in which technology is embedded and taken for granted in the discourses of midwifery practice. Through this small gesture, P7 constructs a fetal heart as extraneous to the body and situates it as being contained within the machine. This resonates with the critique of fetal monitoring technology as 'Deus ex machina' by Sartwelle, Johnston and Arda (2017, p.2) that provides the rationale for the use of the Pinard. The machine is not responsible for auscultating the fetal heart, the practitioner is; the sound of the *heartbeat* is a representation provided by the machine.

As a discursive practice 'routine' aspects of practice such as auscultation of the fetal heart resonate with Foucault's concept of bio-power, where the body is the site upon which 'increasing organization of population and welfare for the sake of increased force and productivity' takes place (Dreyfus and Rabinow, 2014, p.532). For many of the participants, auscultation of the fetal heart is a taken-for-granted aspect of the discourses of midwifery and childbirth, where the fear and anxiety of their responsibility and accountability as learners in the clinical setting is articulated.

The Doppler is presented as a routine aspect of practice (for example P5's *way to do it* and P10's *they seem to use it kind of em all the time not really when it's almost necessary*) which would at first glance seem complicit with the discourses or master narratives of 'midwifery' and 'medico-science'. Closer inspection of the discourses providing clinical guidance for midwifery and obstetric practice[18] in the antenatal period reveal that 'routine Doppler ultrasound should not be used in low-risk pregnancies' and 'Auscultation of the fetal heart may confirm that the fetus is alive but is unlikely to have any predictive value and routine listening is therefore not recommended. However, when requested by the mother, auscultation of the fetal heart may provide reassurance' (NICE, 2017, p.11).

Here the guidance suggests that the fetal heart should only be auscultated by the midwife at the request of the mother. There is no reference to this process made by any of the participants. Their practice is therefore constructed within a cultural orthodoxy rather than the professional ideologies espoused by the SPRME. The AEI is not accountable for the continued professional learning of practitioners that should take place within the institution of the NHS, and students sometimes articulate their involvement in updating their mentors with 'good practice' (Armstrong, 2010; Hughes and Fraser, 2011). Arguably, it is this dissonance that creates the conditions for the gap between theory and practice, rather than traditional perspectives where HEI's and clinical practice are pitched

[18] The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. A Non-departmental Public Body (NDPB) it is accountable to but operationally separate from, the Department of Health (England). The way NICE was established in legislation means that guidance is officially England-only. However, there are agreements to provide certain NICE products and services to Wales, Scotland and Northern Ireland. NICE guidance has become the 'gold-standard' upon which practice should be based.

as instruments of division. Entirely germane to these understandings are the means by which the data was collected, without the visual transcripts there would be little insight into the significance of the material artefacts involved. The participants identities emerged in relation to their constructions and performances of practice within the discourses brought forth by the Pinard and the Doppler.

Constructing and performing identities in relation to discursive spaces and places

Positioning in relation to physical environments was an important aspect of identity constructions. SPRME (NMC, 2009 p. 8 & 21) references the 'approved education institution' and the 'university' offering little else in terms of a definition. For each student, this environment is experienced and constructed in differing ways, not as the static representation provided in the standards. The theoretical components of the programme experienced in the university are positioned by the students in contrast to what is described as *real* midwifery through simulation and subsequently practice. Here, learning is deconstructed into theory and practice, with *a lot* of theory as a recurring theme of the first trimester of the programme.

In contrast to the practice environment, *uni* is characterised as being a bit useless in terms of providing appropriate learning opportunities. Reflecting on commencing practice in the simulation centre after a period of theory, prompted one participant (P11) to tell me that she had thought *yaaay its midwifery* and another to say that learning skills was something that was *really applicable to*

midwifery. Five of the participants described getting *hands-on* in relation to both being out of the classroom and onto the models and being out of the university and 'on' to the women. In doing so, their identities as midwives emerge in the discourses of 'doing midwifery' and therefore 'clinical skills', not in relation to the acquisition of theoretical knowledge. The Simulation and Clinical Skills Centre and the learning within it, becomes a pivot from which to position anxieties around early naivety and the transition to becoming more competent in the clinical setting. One student (P7) comments that having been out in practice she now feels more like a *proper student midwife,* reinforcing the findings of (McIntosh *et al.*, 2013) who argue that in respect of student learning there is a dissonance between the philosophical stance of AEI's, professional regulators and the practice environment.

The practice environments are discursively constructed as diverse and dynamic. Contrary to the SPRME, which again presents a standardised picture of the clinical setting, the student's descriptions of *community, the birth centre, the labour ward* are all different. Local constructions emerge in relation to material artefacts, for example, the mentor's bag which has the Pinard in it, the woman's phone which will record the 'heartbeat' and bear witness to the competence of the student, or the birth plan which documents the unorthodox requests of a woman *in there.*

The serendipitous nature of the allocation of both placement areas and mentors is implicated in the experiences that the students have. Thus both geography and bureaucracy are woven into this discursive field. McKinnon (2016, p.285) describes this as 'a space of overlapping territorial claims, of power enacted

and resisted, and of multiple identities brought into being.' Also acknowledged are the ways in which the 'discursive and the material intermingle' (ibid) and are implicated in the intimate 'geopolitics' of the birth environment which competes 'to govern the birthing body'. In the context of the construction and performance of professional identities, this 'governance' is not just of birthing women's bodies, but also significant are the bodies of the students and their mentors.

The culture of each individual environment is implicated in the identities that the students are able to uptake at that moment in time, for example P1, and her discussion of the *woman in the birth centre.* In this instance, it is the act of resistance of the woman's wishes by the midwives in the story where power dynamics and the politics of caring become visible.

The small stories highlight the requirements of their mentors to process not only the women they are tasked with caring for but also the students as learners. In a discussion of this, Finlay and Sandall (2009, p.1228) draw from Lipsky's (1980, p.3) concept of 'street-level bureaucracy' where workers such as midwives 'work within tightly scheduled and fragmented systems that often do not allow enough time to sufficiently deal with the needs of clients'. In this instance there is a double need, the student needs to learn, but the woman needs to be cared for. The priority then is the 'woman' and as such the student will have to conform to the ways in which her mentor chooses to 'process' her as an aspect of workload.

As persons being processed, time is significant and is constructed by many of the students as a feature that creates the conditions and possibilities for their midwifery identities. What is possible for them is dependant of the 'routines and

simplifications used by health workers to “process people”; the coping strategies they develop to deal with their resultant work frustrations, and the resultant implications for implementing policy on the frontline’ (Finlay and Sandall, 2009, p.1229). Practitioners can choose to prioritise their workload in respect of the organisational requirements placed upon them by the NHS and discount the learning opportunities required by the student of the AEI and the policy imperatives of SPRME.

As Fairclough (1992, p.91) suggests ‘subjects are ideologically positioned, but they are also capable of acting creatively to make their own connections between the diverse practices to which they are exposed, and to restructure positioning practices and structures’. While acting agentively to create opportunities to learn to use the Pinard, for example, procurement where there is a lack, the students construct their experiences as being thwarted by the availability of time as a resource allocated by their mentor. The dynamics of power and ‘relations of domination’ (ibid) relative to the availability of time are significant to their progress to be the type of midwife who is able to use the Pinard. This construction of the ‘mentor’ echoes Finlay and Sandall’s (2009, p.1233) understanding that it is through ‘street level bureaucrats’ accounts of their actions and their sense-making activities that they frame organisational structures as real and time constraining’.

Autonomous selves

If the ethical principle of autonomy is central to the practice of midwifery and can be understood as a concept that seeks to afford self-governance to an

individual, there are implications for this in the construction and performance of identity.

Autonomy as a feature of identity as constructed by SPRME is an example of the subject being interpellated into an ideology ‘in a way which disguises the action and effects of the latter, and gives the subject an imaginary autonomy’ (Fairclough, 1992, p.90). Students are therefore front-loaded with the perception that they must assume positions such as this in respect of their midwifery identities. Where there is ‘contradictory interpellation’ (ibid) such as the struggles that are had with the Pinard, students experience the conditions ‘under which awareness as well as transformatory practice is most likely to develop’ (ibid). Thus, the construction and performance of autonomy through the lens of the Pinard and the Doppler can be seen as a point of questioning, if not resistance, by some of the participants to the ‘taken-for-granted’ subject positions that policy and practice creates.

Autonomy is socially constructed; as Fairclough contends ‘the structuring of discourse practices in particular ways within orders of discourse can be seen, where it comes to be naturalised and win widespread acceptance, as itself a form of (specifically cultural) hegemony’ (1992, p.10). Being ‘autonomous practitioners’ (NMC, 2009 p.5) is a phrase that is widely used in the discourses of midwifery education (Baird, 2007; Nolan, 2017; Hamilton, Baird and Fenwick, 2019). For the students, their identities are contingent on the ways in which they interpret principles such as this and how it gives shape to their practices.

While students are expected to be autonomous practitioners at the point of registration, they are also implicated in supporting autonomy of a different kind;

that which is afforded to women. Newnham and Kirkham (2019, p.2147) refer to this as 'rhetorical autonomy' where they propose that 'institutionalized birth as it is currently organised is inherently unethical; midwives and doctors are expected to place allegiance to hospital policy or cultural practices over respect for the wishes and needs of women'. Moreover, they add that 'the politics and power relations of birth are most often visible only when someone resists them' (ibid, p.2149). If neither the midwife nor the woman is autonomous, then the institution holds the balance of power. Nolan (2017, p.441) contends that the NHS remains 'a hierarchical, antiquated institution' that is 'completely incompatible with the rhetoric of autonomy' and questions where this leaves a newly qualified practitioner. Compliant, perhaps; as P11 suggests in relation to the use of the Pinard: *I know we're meant to and I know that+ [holds Pinard on flat of hand] but it's often difficult in the hospital kind of saying oh well I need to use the Pinard.*

Students then are in a quandary when it comes to their autonomy and the provision of *woman-centred care*, for example, P1 and her construction of the woman in the birth centre who pushes the boundaries of what is deemed *by all the midwives* to be unacceptable practice for the 'birth centre midwife'. This is presented by Newnham and Kirkham as an 'institutional paradox' (Newnham and Kirkham, 2019) where 'dominant medical definitions of risk versus safety' are 'heavily skewed towards the safety of medical procedures and the risk of non-medicalised choices'. Subsequently, midwives may 'overturn their responsibility to woman-centred care to attend to the requirements of the institution not necessarily because they feel a moral duty, but because following policy is their professional safeguard' (ibid, p.8). A paradox indeed.

Where students constructed autonomous practice that countered the accepted wisdom of their immediate environment, for example in the purchasing and use of the Pinard, their pronoun grammar shifts from *we* to *I.* Some told me they had subverted the system in ways that however small, were still trying to put into practice what they understood to be *good* midwifery. Here the students are interpellated into the discourses of 'idealised' midwifery, exemplified in the chalk and talk of the university. McIntosh *et al.* (2013, p.1183) account for this as follows:

> the dilemma experienced by students is provided by a risk averse NHS and professional regulatory bodies that focus competence, safety and the acquisition of measurable skills, which does not sit easily with a university-based tradition of 'liberal' education where all knowledge is negotiable and revisable. Pre-registration midwifery students are not stuck in a theory-practice gap but caught in a chasm between two powerful cultures concerning the application of knowledge.

These *two cultures* are so heavily determined by their particular epistemological hegemony that they fail to intertwine. For example, the SPRME and the University are strong proponents of the concept of 'informed choice', but custom and practice within the NHS might eschew this in favour of time/risk averse practices. The student is therefore required to balance the ontological leanings of the two, one that prioritises the ethical principle of supporting woman's autonomy as in P11 *I know we're meant to* and one that prioritises the medico-legal avoidance of risk P11 *you're just kind of wanting to do what a mentor wants you to do and if they don't say it you don't want to be+ I guess a*

hindrance. Here P11 acknowledges that she understands it is good practice and she should use the Pinard, but in order to do so she has to be a bit of a nuisance and trouble her mentor.

While this disruption exists in the space between the university and clinical practice (well-worn territory in the literature), what is most apparent is the ways in which autonomy, risk work and the construction and performance of identities influence the 'profession' of midwifery. If professions too are social constructs then 'midwives' and 'midwifery' are subject to the same conditions of transformation as any other discourse. Here, professional autonomy is subjugated by the discourses of risk and as such creates a professional paradox. Spendlove (2018, p.23) cautions that 'contemporary risk work and the reconfiguration of professional boundaries' raises concerns for the 'future role and professional status of midwives' and thereby draws attention to the significance of this to professional learning and practice.

Constructing and performing confidence

The SPRME (NMC, 2009 p.43 & 46) stipulate that programmes of education 'must' prepare students to 'be confident in sharing information about common antenatal screening tests' and that 'women can trust/expect a newly registered midwife to be confident in their own role within a multidisciplinary/multi-agency' team. In this instance the modal verbs must and can in the SPRME reinforce the absolute requirement for confidence as a property of midwifery identity. As a further 'essential skill' at the point of registration the SPRME stipulate that a midwife 'inspires confidence, bases decisions on evidence and uses experience to guide decision making'. Not only do newly qualified midwives need to *be*

confident they need to inspire it too. Confidence, however, is constructed in differing ways in the small stories and micro-dramas of the participants. For example P3, who in her verbal story constructs a prior self who is anxious and scared *that was the thing that I probably hated the most and gave me the most anxiety was+ what did you get as the fundal height?* but with her concomitant gestures she situates herself as having confident practice in the present. The omission of these 'less than fully conscious' (Bucholtz and Hall, 2005, p.585) gestures, would only provide half a story.

Without P3's visual transcript, there would be a small story that reflects on an unconfident prior self; however, her confidence and competence in the skill of abdominal palpation play out in her gestures, which is significant to her performance of identity. The visual data illustrates P3's interpellation into the discourses of both midwifery policy and practice and contrasts with her concomitant verbal narrative. Here P3's small story and micro-drama reveal the challenges that the acquisition of 'confidence' creates and highlights multiple points of possibility in relation to what is reified in respect of this.

SPRME (NMC, 2009 p.42) requires that students are confident in 'their own role' in 'sharing information about common antenatal screening tests' and in 'supporting women in normal childbirth'. These seemingly simple statements belie shifting significations of 'role', 'information' and 'normal' all of which arguably depend on local, context-based interpretations of meaning (Scamell and Alaszewski, 2012; Clews, 2013). Being 'confident' is therefore much more complex for student midwives than the SPRME would suggest. Confidence as a concept is not widely theorised in midwifery literature and where it is, it is not

presented as a property of identity (see for example: Hughes and Fraser, 2011; Bäck *et al.*, 2017; Evans *et al.*, 2018). In trying to bridge such a gap and provide a concept analysis for use in their own field of occupational therapy Holland, Middleton and Uys (2012, p.214) define confidence as:

> a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and a belief in the role, scope of practice, and significance of the profession, and is based on their capacity to competently fulfil these expectations, fostered through a process of affirming experiences.

Although somewhat lengthy, this illustrates that confidence, as a property of professional identities, is challenging and multi-faceted. While students may be confident in who they are, they may not be confident in what they know and how to inculcate this as part of the 'affirming experiences' described above. Further, the construction and performance of confidence as a property of identity presented in the small stories and micro-dramas is often situated in the discourses of risk, expressed in positions of fear, doubt and uncertainty. P8 exemplifies this in relation to having the *face* of confidence. P8 realises the appearance of having a confident professional *face* is an important transitional element of her student midwifery identity. Here, confidence is constructed as having a dramaturgical component, redolent of Hochschild's (2013, p.7) 'emotional labour' which necessitates the 'the management of feeling to create a publicly observable facial and bodily display' this with the aim of producing the 'proper state of mind in others – in this case, the sense of being cared for in a convivial and safe place'. This requires the ability to regulate what is felt

internally, with what is expressed and achieved externally. Emotion 'work' has been explored in relation to midwifery practice (Hunter and Warren, 2014; Crowther *et al.*, 2016) and where the development of 'resilience' was initially proposed as the means by which to counter the cost of this 'work', this has latterly been recanted with the imperative refocused on the requirement for the NHS to instantiate institutional and cultural change from within (Hunter *et al.*, 2019). Further, following recognition of the impact of emotion work on students and new practitioners (Davies and Coldridge, 2015b; Coldridge and Davies, 2017) current thinking suggests that 'proactive support needs to be offered to younger, recently qualified midwives and midwives with a disability to help sustain their emotional wellbeing' (Hunter *et al.*, 2019, p.1).

Enabling the development of confidence as a pedagogic imperative does not feature strongly in the University curriculum; and while attempts have been made to address this through educational strategies in midwifery (Mcluckie and McHugh, 2013) and the SPRME, it is under-prioritised in both.

In contrast to the dramatic face required of P8, P15 lends a somewhat comedic angle to the construction of confidence. Her confidence is proportionate to the unattainable practices that arise in the 'old wives' tales' (Dalmiya and Alcoff, 1993) of midwifery discourses. Having told me that she has *still never felt ears and stuff* (at the time of the interview I felt an ethical duty to inform her that it would be unlikely she ever would - I didn't), P15 positions herself in relation to the 'myths' of clinical practice. Confidence as an aspect of identity is therefore also enmeshed in the stories and storytelling of midwifery. Again, this presents challenges beyond the scope of how SPRME constructs 'midwifery'. Oral

histories ‘connect the individual and the social, drawing on culturally agreed upon (or disputed) mental sets and modes of expression to tell one’s story’ (Shopes, 2013, p.136); and also therefore, the story of one’s profession. As such they provide powerful cultural touchstones for identity construction in midwifery practice. As a practising midwife I spent many years palpating abdomens trying to feel ears, needless to say this was entirely futile.

While there is no doubt that ‘ears’ and such like raise questions regarding claims to knowledge, it is unquestionably the case that oral history and the ‘craft’ of midwifery practice has been ‘banished to the epistemological fringes’ (Dalmiya and Alcoff, 1993, p.217) on account of evidence-based practice and techno-scientific progress (Davis-Floyd and Sargent, 1997). Midwifery histories, in all forms, provide the discursive threads that tie together current understandings of professional identity. It is important therefore that the stories which constitute the ‘epistemological fringes’ of midwifery practice continue to be told.

Being competent – the discourses of policy, learning and practice

Despite detailing many competencies that student midwives must achieve to enter its register, SPRME (NMC, 2009) does not define the meaning of ‘competence’. As the function of the NMC is to ‘protect the public’, the concept of competence is the discursive practice by which the public are reassured that registrants are fit for purpose. Eraut (1994, p.165) suggests that ‘the scope of a professional’s claim to competence has always been a contested issue’ and

proposes that this arises in that group's need to 'occupy and defend for its exclusive use a particular area of competence territory'. While this is one aspect of the purpose of professional competence, the other is to limit the scope of practice in order to protect the public (ibid). Competence is therefore multi-faceted and integral to professional identity, and it features heavily in the SPRME and the discourses of the students.

Despite this, no attention is given to the meaning of competence in the discourses of midwifery policy. A definition is given in the Standards for Pre-registration *Nursing* Education (NMC 2010) about which no application to midwifery is mentioned. Of note is its adaptation from the 'Queensland Nursing Council 2009'; as a feature of intertextuality this is significant and raises an issue as to why the NMC does not develop its own. It states competence is 'a holistic concept that may be defined as "the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions" (adapted from Queensland Nursing Council 2009)' (Nursing and Midwifery Council, 2010, p.11).

Exploring competence in Nursing and Midwifery, Schostak (1996, p.3) proposes that saying 'a professional is competent has a comforting ring, particularly if the client is facing major surgery'. He then goes on to discuss the difficulties in arriving at an acceptable definition, but provides the perspective that 'competence is a social reality or construct, if not real in-itself, then real in its effects in terms of people organising activities with reference to something they label 'competence' (Schostak, 1996, p.4). Fullerton, Thompson & Johnson (2013, p.1130) help with definitions of both competence and competency in

relation to midwifery practice and suggest that generally ‘competence is discussed in relation to behavioural tasks, and competency in relationship to the personal characteristics that underpin the performance of those tasks’. All of which echoes the ways in which the discourses of policy and learning construct the terms, rather than the ways in which they are constructed by the participants in this study.

P5 constructs competence in relation to her *good mentor*, ticking a *competency* off a list, and *time*. *Really good* mentors make the time to support the students with tasks such as using the Pinard. Although the students construct the achievement of their competencies as part of their student midwife identities, this is not constructed by the participants as a priority for their mentors. Integral to this is the way in which time, as a feature of organisational and managerial discourses, is positioned. Time in this sense, is relative to the power that the mentor has to prioritise and organise the ‘work’ required to become competent. Here, P5’s construction of competence is situated within what Schostak (1996, p.6) describes as ‘technicist and behaviourist approaches to the assessment of competence’ which he argues are ‘predicated on the notion that predictability of outcome is possible in human activity’. Competence as an outcome that requires negotiating with one’s mentor at a time, a place and a mindset that is mutually convenient is not constructed as such in the SPRME.

For P5 then, a complex chain of elements must combine in order for her to be ‘competent’. The end result, a signature in a box, is the imperative rather than the significance of being competent in the action in the context of the midwife/mother relationship and the provision of care. Competence for P5 and

indeed many of her colleagues is an ‘intersubjective framework for organising experience, knowledge, interpretation, understanding, judgement, decision making and action’ which is ‘less to do with safety, good decision making…….and more to do with legitimation, and politics of professionalisation’ (Schostak, 1996, p.4). To counter this, a more meaningful engagement with professional doing and being is required. The implicit argument proposed by Schostak (1996, p.12) in respect of this from a pedagogic perspective is that ‘professionality is a continuous process of critical interrogation of action in light of the ‘prime reason’. In midwifery the ‘prime reason’ for being there is arguably to give care to women and their families, something which seems underplayed in the participants constructions and performances of ‘competence’.

Both education and practice are implicated by P9 in failing to support the achievement of competence *that’s a point+ did we get to use one of these? I don’t think we did+ in uni+ I think someone showed it to us and said this is a Pinard+ and this is what you do with it and we watched a video+.* When analysing the assessment of competence Bedford *et al.* (1993, p.11) suggest attention is given to ‘the function it serves within a symbolic system or social process, how it is related to other elements or features, how it is accomplished as a practical activity’. With this in mind, competence in the use of the Pinard is symbolic within both craft and regulatory midwifery discourses but is not prevalent in the midwifery discourses which constitute ‘practice’ for the students. It is therefore possibly anachronistic in relation to other elements – the Doppler for example, and as a practical activity appears to be poorly supported in education and clinical practice. Returning to Schostak (1996), for the participants this competency becomes symbolic of a discursive marker

which legitimises professional identity, rather than an action implicated in safety and good practice.

P11 frames her lack of competence in the context of not wanting to be *a hindrance.* Suggesting that the dynamics of the mentor as a silent power figure are in play. Undoubtedly, for some of the participants, the fear of being a nuisance influences their ability to assert their learning needs in the practice area. Where a student might press their mentors for support with competencies, such as the use of the Pinard, there is a reluctance to trouble them with their needs. Reinforcing the limitations of practice and the ability of students to be provided with appropriate learning opportunities, Armstrong (2010) supports the notion that where students are required to practice in a given way by their mentor this might be contrary to what they as students understand as good practice. Fear of jeopardising clinical marks and career opportunities was found to inhibit their being able to counter this.

The achievement of 'competency' using 'lists of procedures, skills and knowledge' is discussed in a broader context by Bedford *et al.* (1993, p.7); perceiving it as inherently problematic, they suggest it 'fails to take any account of the complexity and dynamism of human interaction and organisational processes'. In 1996, twenty-five years ago, Schostak (1996, p.11) suggested that to remediate this the 'discourse of competence is increasingly replaced by a broader more complex discourse of dialogue, debate, critique, evidence'. This message does not seem to have been picked up by the NMC through the SPRME (2009), or indeed by HEI's who continue to use the competency assessment frameworks described.

Responsible and accountable selves

SPRME states that 'education programmes must be designed to prepare students to practise safely and effectively so that, on registration, they can assume full responsibility and accountability for their practice as midwives' (NMC, 2009 p.5). This is no small task, and acknowledgement of this is articulated in various ways by the participants in their small stories and micro-dramas. While some, for example, P1 articulate their conceptualisation of 'responsibility' overtly *it is one of those things that is actually quite a big responsibility as well,* others frame it more covertly as in P3's construction of a woman asking *can I record this? my husband's not here.*

The SPRME positions responsibility and accountability at the level of the individual practitioner and at the level of the AEI in terms of preparing students to become this. Clinical practice is not presented by the SPRME as an agency-bearing environment that has a requirement to prepare students to become responsible and accountable, but is constructed by the students as being implicated in their ability to do so. As discussed in Chapter 5, student midwives are constructed as requiring to be prepared to '*accept personal responsibility for their own ethical choices*' (NMC, 2009, p.6). This requirement to be responsible and accountable is taken up and resisted in the performances of student midwife identity in overt, subversive and subliminal ways. Fenwick (2016, p.8) proposes that

> the social contract of obligation structures responsibility in a particular way, which may or may not be consistent with the personal professional values of the person, or her feelings about what is 'the right thing to do'.

> That moment also is nested within the historical and cultural routines, as well as the built environment of the action – all systems which embed moral determinations of what constitutes good practice, or at least what was considered good practice at some point.

The moment that this is 'nested' (ibid) in for the student midwife and her identity as a responsible and accountable subject is complex and contingent on many factors. Not least of which is the perspective of the women, to whom the student will also be responsible and accountable. Complicating this further is the ethical principle of autonomy; afforded to the midwife in terms of her practice, and the woman in terms of her choices. All of which is further undermined by complex discourses such as risk, which as a hegemonic concept is woven through the discourses of policy and embedded in the fabric of practice (Hindley and Thomson, 2007; Scamell and Alaszewski, 2012; Scamell, 2014; Divall, 2018).

The SPRME state 'women can trust/expect a newly registered midwife identifies and manages risk safely and will reduce or remove risk that could be detrimental to women, self and others' (NMC, 2009, p.48). For the students, constructions of accountability and responsibility are situated in terms like *terrifying, testing, anxious,* and *worried* as regards what it means to give care to women in practice. P10 envisages an experience which foregrounds the isolation of what it means to be accountable and responsible, telling me that using the Doppler is *quite a scary thing and there have been times where I would rather use that+ rather use a Pinard because- because I think+ what if this is that time when actually I can't find- and if I am on my own+ what if I can't*

find a heartbeat. Perhaps one of the bleakest professional scenarios constructed by the participants.

In contrast, the language of the SPRME in respect of risk is objective and rational (Skinner and Maude, 2016) in that it simplifies the concept of risk to something that can be controlled and managed at the level of the individual. At a broader socio-cultural level, risk theorist Ulrich Beck (Beck, 1996, p.1) proposes the 'risk society'. Here, commensurate with a growing awareness of risk and the means by which to mitigate it, comes the increasing requirement to apportion blame and accountability. Nowhere is this more evident than in the context of birth.

Exploring risk in relation to 'the ever narrowing window of normality during childbirth', Scammell and Alaszewski (2012, p.207) found that 'normality only existed as the non-occurrence of unwanted futures, imagined futures where things went wrong took on a very real existence in the present'. For students, perspectives such as these permeate the discourses of practice. Despite the rhetoric of retrospective normality being challenged in midwifery discourses (Coxon *et al.*, 2016; Skinner and Maude, 2016; Newnham and Kirkham, 2019) 'blame' cultures continue to shape what practitioners are prepared to be responsible and accountable for. This creates a tension in how the midwife is envisaged in policy and how practicable this is for the midwife. As such, positions of anxiety, terror and worry are part of a broader problem that 'goes beyond individual midwifery practice and needs to be addressed at a macro level' (Plested and Kirkham, 2016, p.34). Not only is the obligation and the ability to be responsible and accountable for practice enmeshed in treacly

discourses of organisations and environments, but it is also contingent on the relationships between practitioners and the women in their care.

Conceptions of the 'mediative' or power limited caring professions (MacDonald, 1995) arise in gendered and patriarchal discourses whereby autonomy and role function is limited to the 'mundane' under the authority of the 'superordinate medical profession' (ibid) within the National Health Service. This creates a tension between professional groups and their understanding of who is responsible and accountable, and for what. While students are required to be autonomous practitioners (and therefore accountable and responsible) as regards the SPRME, women are afforded similar as regards the choices they make for birth. Both positions are problematic in that neither intersect with, or have control over, the managerialising discourses which organise practice.

Embodied selves - being a woman and being with woman

Discursive constructions of pregnancy are heavily imbued with socio-cultural norms, and as such women are 'constituted as objects of public surveillance' and as being 'in a culturally created struggle between their needs and those of their future babies' (Sutherland *et al.*, 2014, p.111). Akrich and Pasveer (2004, p.65) describe this as how bodies and self are 'performed in birth narratives through the mediation of a number of significant elements', including technical devices like the Pinard and the Doppler. The 'women' and the care they are given are constructed in relation to these 'elements'; although they are not reflective of 'reality' but constitute 'the reality we are interested in' (ibid). The SPRME (2009) construct women varyingly and somewhat passively, for example as members of 'the public' as 'stakeholders' and as the recipients of

competent practice ‘women can trust/expect a newly registered midwife to’ and ‘woman-centred care’. They are not accounted for in their visceral and fleshy states or indeed encumbered by thoughts and opinions, as intellectual and emotional beings.

References by the participants to the *woman* as the focal point of care construct them as ‘woman-centred’ and the providers of ‘woman-centred care’ positions arising in the discourses of professionalism and learning. The term ‘woman-centred’ is arguably overused and under-defined, prompting Fontein-Kuipers, de Groot and van Staa (2018) to conduct a concept analysis. Their findings acknowledge the complexity of arriving at a definition,[19] particularly where ‘care’ can be understood as having an ‘active or passive form’ (ibid, p.8) which ‘would make the midwife the active and the women and child the passive recipients’. Thus contradicting the ‘woman-centred’ philosophical underpinning of the term. For some of the participants, the abdominal model, the Pinard and the Doppler become characters through which they constructed stories of reductionism and holism of women relative to their experiences in learning and practice environments. In doing so, they present the distinctions of perceiving women objectively as ‘parts’, and holistically as distinct human beings. This is not only with the embodied identities of the woman but also in respect of their identification with axiological aspects of being ‘woman-centred’ and providing ‘care’. For some, the rationale for their practice is constructed under the auspices of what is *nice* for women. This positioning of themselves as the

[19] Woman-centered care is a philosophy and a consciously chosen tool for the care management of the childbearing woman, where the collaborative relationship between the woman - as an individual human being - and the midwife - as an individual and professional - is shaped through co- humanity and interaction; recognizing and respecting one another’s respective fields of expertise. Woman-centered care has a dual and equal focus on the woman’s individual experience, meaning and manageability of childbearing and childbirth, as well as on health and wellbeing of mother and child. Woman-centered care has a reciprocal character but fluctuates in equality and locus of control.

benevolent, woman-centred practitioner is characterised by Davis-Floyd (2001, p.107) as 'overly romantic' as she argues that 'what is best for birthing families cannot be determined by one-size-fits-all programs and evaluations'.

The discourses of shape and size are also used as a means to negotiate the ease with which the students can 'do' midwifery practice. Where women are *lovely and slim* (P14) it is easier to be a midwife and where women have a large *BMI* it is harder. As P14 states *the first time I tried using this she [the mentor] asked me to do it on a woman whose BMI was greater than 30+ just to see how i would cope i think.* Illustrating how women's bodies become a site of struggle for students, either as a help or as a hindrance. P9 situates her own discomfort in relation to corporeal affairs as being *a bit embarrassed about rummaging around in someone's pants.* P9 raises the issue of inter-subjectivity and professional identity *I'm always measuring a bit differently from my mentor and I think that's because I'm not quite sure where the pubic bone is.* Or possibly because they are different people measuring a bit differently. Superficially, the assessment of gestational size relates to the collection of data required to 'monitor' pregnancy, but also arises in the discourses of fitness and beauty that permeate the aesthetic of 'good mothers'. In a study examining how the pregnant body is constituted using language, Sutherland *et al.* (2014) explore how 'white, middle-class, able-bodied practices of embodiment' permeate constructions of pregnancy and the 'good' pregnant woman. Where there is a deviation from socially accepted/constructed body mass, bodies are 'turned into objects of media and public gaze' (ibid). Drawing from Foucault's concept of biopower, they argue that constructions of the pregnant body in ways such as this can contribute to social injustice and inequality. This is apparent in the

performances of the students in relation to the use of the Pinard, where women who are perceived as being too large or too active are not considered as suitable candidates for gaining competence and enhancing their clinical skills.

This construction troubles the discourses of midwifery practice, which position midwives as caring, supportive and woman-centred. In respect of this contradiction, Charles (2012, p.1) argues that 'feminist theorists have spent a lot of time critiquing the medical model of childbirth. By contrast, they have paid little attention to the midwifery model because they widely assume that it empowers women.' This, she goes on, is because 'since feminists tend to presume that the midwifery model is a better way to conceptualize childbirth, few have devoted much time to analysing the promotion and implementation of the midwifery model'. Charles goes on to question the negative impact that midwifery discourses can have on women's experiences of childbirth using the phrase 'shame, failure and isolation' to illustrate. SPRME (NMC, 2009, p.5) characterises midwifery as concerning 'the promotion of the normal physiological process of childbirth'. Having these parameters carved out for practice has arguably created a discursive preoccupation with 'normality' over 'woman-centred' practices. This can have great consequences for all those concerned, as the Report of the Morecambe Bay Investigation (Kirkup, 2015) and more recently the Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (Ockenden, 2020) detail.

Conclusion

In contrast to the SPRME (NMC, 2009), the positions taken by the participants surface the discursive struggles that they experience in becoming midwives. Their ability to identify with 'good' midwifery constructed by the AEI is hampered by competing discourses that extend beyond the *uni* and out into clinical practice. There is a tension between being a 'student' with *a lot of theory* and being a 'student midwife' who gets *hands-on*. Not only is this tricky, but there are different types of 'midwifery' and different types of 'midwives' depending on clinical and interpersonal environments. The students are therefore consistently required to manipulate their 'selves' in order to meet these differing discursive constructions. The identities of the students emerge at the intersection of the multiple and often contradictory ideological processes involved in the construction of 'midwives'; for example, those of the AEI, the SPRME, and the institution of the NHS. Added to this are their own experiences and interpretations which enable them to 'restructure positioning practices and structures' (Fairclough, 1992, p.91) and bring forth multiple possibilities of what their identities as 'midwives' are.

Ball (2013, p.15) proposes that 'the practitioner, the professional is also brought into being by the knowledge that makes them expert' and that 'knowledges are produced within power relations also in the sense that some groups or institutions have been able to speak *knowledgeably about* 'others'. Here there is a relationship between the implications of this knowledge and how it materialises at the level of policy and at the level of the individual. The participants construct their midwifery identities not in the context of their

academic capability, but with regard to what they can ‘do’. In the context of practice they are able to articulate the discourses of education in relation to this but are interpellated in the discourses of the clinical environment and those of their mentors.

Predominating the discourses of the clinical environment (albeit as hegemony) are concepts of ‘risk’, arguably the key construct within which midwives’ identities are shaped (Scamell and Alaszewski, 2012, 2016). Against this template, the avoidance of blame is paramount where ‘the challenge for midwives is that, despite their efforts and commitment “blame-free” birth does not exist’ (Scamell and Alaszewski, 2012, p.218). As birth becomes increasingly technocratic (Davis-Floyd and Davis, 2018), the delineation between who is accountable and responsible has become increasingly problematic.

There is also the possibility of a misinterpretation of ideological components of identity invested in the discourses of the SPRME; for example with concepts like autonomy, accountability and responsibility. Here Fairclough (1992, p.90) contends that ‘contradictory interpellation is likely to be manifested experientially in a sense of confusion or uncertainty, and a problematization of conventions’. The recommendations proposed by Kirkup (2015) and Ockenden (2020) in response to failings in practice suggest that these aspects of professional identity are undoubtedly implicated in safe and effective care; with ‘confusion or uncertainty, and a problematization of conventions’ being antithetical to this.

The concept of ‘fitness to practise’ (NMC, 2009) becomes relevant here as students become enmeshed in doing what is expected for the institution, rather

than adhering to the professional standards and behaviours stipulated by the SPRME; this is often paradoxical and a source of professional tension. Being 'fit' is comprised of many things, crunched by the NMC into an innocuous bundle of 'skills, knowledge, good health and good character'. All of which must be evidenced at point of entry to the 'register' and then on a three-yearly basis through the process of 'revalidation' (NMC, 2017). Having been deemed 'fit' a pin number is issued to the midwife which identifies the person as a registrant. Getting your 'pin' is perceived as a badge of honour by the fledgling midwife, but this or the name of the individual can be used to check the 'status' of a registrant on the relevant NMC website. And a similar process can be used by anyone to refer a registrant to the NMC if there are concerns about their 'fitness' to practice. Entirely appropriate when circumstances necessitate this, but there is no mitigating for grudge bearing or malicious referral. In this way the 'register' can be seen as a site of regulatory power and control. Foucault, however, cautions that power should cease to be perceived in negative terms: 'power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production' (1979, p.194). This process, the panopticon of policy, also removes the need for 'direct supervision' in relation to safe and effective practice. Through the regulatory discourses of the SPRME the NMC 'safeguard' the public and practitioners through the 'realities and rituals of truth' (ibid) that are discursively propagated.

This raises the possibility that the midwife imagined in both the SPRME and in the discourses of education is a myth, as Laclau and Mouffe (2015, p.82,97) suggest 'there is no sutured space peculiar to "society", since the social itself

has no essence' and as such 'there is no identity which can be fully constituted'. If this is the case, then there is a pedagogic imperative to consider those elements which should come together to determine this field. Fairclough argues that there is 'a strong case to be made for a model of language education which emphasises critical awareness of ideological processes in discourse', this with the aim of enabling self-awareness in relation to practice (Fairclough, 1992, p.90). Significant to this is the means by which people come to be made aware of the 'ideologically invested discourses to which they are subjected' (ibid) and therefore the function of language in the construction of the self and the social world.

Revisiting the aims of the thesis

At the beginning of this thesis I aimed to question what is taken for granted about midwives' identities. I aimed to explore the ways in which the discourses of policy, professionalism and learning construct midwifery identities as 'social realities' (Fairclough, 1992, p.169) and consider how these social realities are taken up or resisted within the discourses of student midwives as they construct and perform *their* professional identities. The research question asked was 'What are the discourses within which student midwives' professional identities are constructed and performed and what significance does this have for professional learning and practice?'

This thesis emerged in part as a response to a student questioning the stultifying effects of her midwifery programme, and my acceptance and complicity in the preservation of the status quo as regards this. If 'any system of education is a political way of maintaining or modifying the appropriation of

discourses, along with the knowledges and powers which they carry' (M Foucault, 1984, p.123) then it is imperative to explore what is being maintained or modified. As well as recognising the ways in which identities emerge in and through discourse, exploration of the tendency for change within discourse has an important contribution to make to perspectives of the social world, and that which constitutes practice (Fairclough *et al.*, 2009). The aim of this thesis, therefore, was to explore the order of discourse relative to the construction of midwives' identities in order that new knowledge and understandings could provide commentary and perspectives to inform future practice.

Strengths and Limitations of the study

A strength of this study relates to how it has addressed the gap in the literature presented in Chapter 2. As discussed in the research design chapter the purpose of the research was not to create 'generalisable' findings that can be applied across the field, instead the aim was to analyse policy and practice to illuminate the means, practices and resources by and through which student midwives construct their professional identities. This in order to point out 'what kinds of assumptions, what kinds of familiar, unchallenged and unconsidered modes of thought the practices that we accept rest' (Foucault, 1988, p.154). The knowledge generated by this research an important contribution to make to professional learning and practice in midwifery. Another strength is the development and application of new methodologies that have the potential to extend understandings of the means by which the material comes to influence and constitute practice.

I underpinned this study with BERA's (2018) ethical guidelines for educational research. In doing so I aimed to conduct the research with an ethic of respect. I considered the persons involved, their knowledge, democratic values, the quality of the intended work and the academic freedoms afforded to me. With regard to the discourse analysis of the SPRME I am arguably immersed in my own discursive constructions as regards identity, and have therefore tried to follow Fairclough's (1992) process for analysis to mitigate this.

Contribution to knowledge

Policy constructs midwives - contributing to knowledge through the discourse analysis of the SPRME

Using discourse analysis as the means to interrogate the SPRME, it is proposed that they reflect the ideological imperatives of the NMC. As such I argue that the 'midwives' of policy are regulatory hegemony. Medico-legal discourses reinforce a strong sense of regulatory power and control, in respect of this Ball (2013, p.30) suggests that power is not 'a structure but rather a complex arrangement of social forces that are exercised; it is a strategy, embedded in other relations'. For example by interdiscursively employing ethical principles, the SPRME construct midwives as agency-bearing, autonomous, accountable and responsible practitioners.

Permeating these constructions are the discourses of risk and responsibility, with students being required to demonstrate competent, confident and woman-centred practice through the provision of evidence-based practice and lifelong learning. Here I suggest that these identities are constructed in a discursive

space where they can only fully emerge ideologically. Identity is understood in this thesis as the 'social positioning of the self and other' (Bucholtz and Hall, 2005, p.586) and the identities of the regulatory midwife are brought forth as 'other' to those constructed and performed by the students. The field of discourse that organises the social practice of 'midwifery' is determined by myriad perspectives, many of which exert a subjugating force on the abilities of practitioners to be held to the ideological ideals articulated in the SPRME.

The students presented a more complex and intricate picture of their professional identities than the SPRME. The discourses within which the students constructed and performed their identities were much more embedded in concepts of clinical practice. Both the University and clinical practice can be viewed as a site where policy is enacted and as such are implicated in the subject positions that student midwives are able to take up. These constructions were predicated on their being 'other' to types of midwives, environments, clinical practices, women, and ultimately the identities required of them by the SPRME in relation to autonomy, accountability, responsibility, confidence and competence. As a discursive practice, Fairclough (1992, p.207,209) states that the processes of education contribute to this through 'commodified educational discourse' which is 'dominated by a vocabulary of skills….and a whole working of the processes of learning and teaching'. He suggests that this goes towards providing 'hands' for the 'market' in this case for the NHS. This provision of 'hands' raises a tension between the NMC and the AEI in respect of power; the NMC through the SPRME limit the capability for the AEI to exercise pedagogic creativity. In doing so, this covertly propagates a

degree of anti-intellectualism at odds with the rhetoric of the ‘academy’ (Preston and Aslett, 2014).

In these environments emerging professional identities are constantly subject to surveillance (for example, in relation to ‘fitness to practise’) through the discursive practices employed. Described by Foucault (1979, p.187) as an effect of ‘disciplinary power’ it ‘subjects a principle of compulsory visibility’ where the ‘fact of being constantly seen, of being always able to be seen, that maintains the disciplined subject in his subjections’ is recognisable in the constructions of the students. Here, Ball (2013, p.70) suggests that ‘within these relations, in these spaces of definition, particular forms of knowledge are enabled to emerge and provide a conceptual infrastructure for professional practice’. It is within these spaces that this thesis makes a contribution.

Discursive mismatches – contributing to knowledge of the construction and performance of identity in midwifery

At the time of writing, there is so much change in midwifery education and practice it is almost unfathomable, and from here, there are significant possibilities for the sedimentation of new and different discourses. Now more than ever, midwives need to protect the professional space that they occupy in order to give appropriate support and care to women and their families. Recent reports present a desperate picture of the impact of poor quality maternity services in parts of the UK (Ockenden, 2020), with key findings in relation to maternal and infant deaths suggesting failings in aspects of emotional care and compassion, the assessment of risk, clinical care and competency, the escalation of concern, and poor practice relating to monitoring fetal wellbeing.

While this picture is not representative of all maternity services in the UK, it makes for sobering reading. The salience of this in relation to professional identity as it is discussed in this thesis is highly significant; aspects of autonomy, confidence, competence, responsibility, accountability and embodied selves are all implicated in Ockenden's findings.

Although understanding the ways in which professional identity is constructed and performed provides insight into those discourses which impede (and possibly counter) progress, and those which enable it; at present my thesis indicates that there is a disconnect in the order of midwifery discourse as to how student midwives are discursively constructed in the SPRME, the AEI, and those identities that they construct and perform themselves. Where there is a professional duty to safeguard the public, it is a requirement to understand which of these identities is fit for purpose. Birth is inherently and increasingly complex, and just as the 'midwife' is a myth, so is the 'normal' birth that falls within their remit. If the SPRME are the means by which the 'public' understand what midwives are responsible and accountable for, then a limited picture of what constitutes professional practice is presented. For student midwives, the intellectual project of professionalism is not prevalent in their constructions and performances of their midwifery identities. Instead, *real midwifery* is what is done with the hands upon the surface of the body.

The micro-drama - contributing to methodological knowledge through the analysis of gesture and 'small stories'

This thesis has questioned what is taken-for-granted about standards, policy, learning and practice and how as discourses they shape midwives' identities.

The refractive lens of the Pinard and the Doppler provide an allegorical position from which to view the material practices of ‘midwives’ and ‘midwifery’. If the discourses of risk, techno-science, medicine and midwifery are the big story, the Pinard and the Doppler provide the allegory for which. In the absence of a methodology appropriate to my needs I developed the micro-drama as a means to explore gesture as an aspect of small story analysis.

There is much known about the ‘macro’ in relation to identity, but much less is known about ‘micro’ constructions, particularly in midwifery and particularly in relation to narrative accounts of gesture. The development of the micro-drama as a methodology highlights the value of using small stories and gesture an aspect of multi-perspectivism in the research process. The significance of the data that emerged from the gestures of the participants cannot be underestimated, Janney (1999, p.963) suggests that ‘when what is literally “said” is contradicted by what is gesturally “shown”, the figurative gestural message almost always overrides the literal one in people’s interpretations of acts of speech’. Gesture and gesture mismatch therefore become an important aspect of narrative inquiry. Significantly, this emerged in relation to the Pinard and the Doppler as the material objects I used to constitute practice. As material fragments of a huge discursive practice, they are threads that influence how the micro and the micro are woven together in the construction and performance of professional identity, with both yielding different but sometimes similar patterns for students.

The interplay of acceptance and resistance of approved discourses has implications for all forms of professional discourses and therefore the micro-

drama and gesture as an aspect of small story analysis has an important contribution to make to methodologies for narrative inquiry. The development of the micro-drama is where I offer a contribution to knowledge as a research methodology.

Chapter 9 - Conclusion – Powers, passages and passengers

Introduction

At the beginning of this thesis I proposed the use of the metaphor ‘powers, passages and passengers’ and suggested it would be employed figuratively to represent the powers of policy, the passages of educational practices and the student midwives as passengers therein. Through my discourse analysis of policy and the empirical study of the student midwives, I have demonstrated how the powers and the passages, be it the might of the NMC, the insouciance of the *Uni,* the silent power figure of the mentor, or the spectre of risk, come together and create the conditions within which the passengers as subjects emerge. In this chapter I conclude the thesis and provide the implications of the study in relation to the powers, passages and passengers of policy, and professional learning and practice in midwifery.

Powers

Foucault argues that the disciplinary power of policy ‘normalises….. analyses and breaks down; it breaks down individuals, places, time, movements, actions and operations. It breaks them down into components such that they can be seen on the one hand, and modified on the other’ (1979, p.56). ‘Midwives’ and their professional identities have therefore been explored through the contrasting ‘components’ arising in the discourses of the NMC and the small stories and micro-dramas of the participants. In this context, these

constructions and performances are reflective of regulatory, educational, professional, midwifery and biomedical and techno-scientific discourses.

The protected title ‘midwife’ does not come alone, regulatory discourses require practitioners to subscribe to the ‘micro-politics of little fears’ (Lazzarato, 2009, p.120) that neo-liberal policies utilise to manoeuvre subjects into position. For example, the framing of the midwife as being ‘responsible and accountable’, ‘autonomous’ and accepting of ‘responsibility for their own ethical choices within specific situations based on their own professional judgement’ (NMC, 2009, p.5,6) does not reassure the student transitioning out of the university and into clinical practice. The clinical environment is heavily regulated by policies and ‘guidelines’ of a different sort and does little in the way of supporting autonomy but much in the way of determining accountability. Midwifery practice does not occur in a vacuum and it is often the case that we know more about the limits of what it means for midwives to be autonomous, responsible and accountable after these limits have been transgressed. The discourses of regulation, therefore, construct a midwife that ‘must’ be compliant with the conditions that are required of their registration. This despite competing discourses, for example those laid out in the terms of their employment or those expressed by the women in their care, that may limit their ability to achieve this. Here regulatory power ‘protects the public’ with its swift and fair approach, and holds the individual to account through the disciplinary power that is the ‘spectacle of the scaffold’ (Foucault 1979, p.279) maintained through ‘the register’ and the unique identifier that is the ‘pin number’.

Passages

Exploring the concept of ‘discourses’ as spaces which organise identity provides a means to see where the ‘midwife’ emerges. Ball (2013, p.20) discusses discourse and suggests a ‘statements make persons – we do not speak discourse, discourses speak us’. Concomitant with this is the notion that discourse is not language alone and that ‘the materiality of discourse also draws attention to architectures, organizations, practices and subjects and subjectivities (including the author) as manifestations of discourse’ (ibid). Thinking about midwifery in this way it is necessary to consider materialising for further scrutiny the University, and the various clinical environments, in order to develop understandings of the ways in which these become written onto and into ‘the body’ of the midwife.

Passengers

Discursive constructions of midwives’ identities are not new. Using the concept of ‘genealogy’ Foucault (1984, p.82) proposes that its task is to ‘expose a body totally imprinted by history’ in order to understand the emergence of the subject. Some of the earliest recorded statements about midwives are good examples of this, Borrelli (2013) looking at historical perspectives of ‘midwifery’ examines some of these early works. This includes two texts describing ‘midwives’ written by Soranus and Pliny in the second century AD; both describe behaviours, values and personal characteristics rather than knowledge acquisition. The lack of focus on theoretical criteria is put down to women’s illiteracy and the impetus for knowledge being passed on through verbal and visual conduct rather than as a learned text. They describe a midwife being: literate (ironically) with her

wits about her; not unduly handicapped as regards her senses, loving work; respectable; robust, long fingers, short nails etc. Most of these characteristics emerge in a recognisable form of sorts in modern texts. It is important to consider how these characterisations are accepted and resisted over time and which of those become sedimented into the discourses of practice. Dreyfus and Rabinow (2014, p.2759) describe Foucault's analysis of the genealogical body as 'the place where the most minute and local social practices are linked up with the large scale and organization of power'. The students then, as passengers constructed within discourses that shift over time, are the minute surfaces upon which identity becomes visible; but only temporarily.

Implications for professional learning and practice

Midwifery, as it is constructed within the NHS, unlike the two-dimensional constructions of the SPRME, requires the development of the self alongside constantly shifting actors and terrain. It involves for example, the issue of challenges to see how students *cope* with the size and shape of women, the intrusion of technology via the mobile telephone, and oral histories which construct impossible subject positions. Of interest is how quickly the participants are interpellated into the language of midwifery practice, whereas the 'university' is almost featureless in many of the accounts of the participants. Where it is characterised, it is often inadequate in helping with 'the labour of becoming' (Venn and Terranova, 2009, p.3), where aspects such as theory are interminable and poorly explained. Ball (2013, p.15) proposes that 'the practitioner, the professional is also brought into being by the knowledge that makes them expert' and that 'knowledges are produced within power relations

also in the sense that some groups or institutions have been able to speak *knowledgeably about* 'others'. Here there is a relationship between the implications of this knowledge and how it materialises at the level of policy and at the level of the individual.

Professional learning in midwifery should pay significant attention to the disparity between understandings of what midwives 'must' be and what they are able to be. Where there is potential for misinterpretation of concepts such as autonomy, accountability and responsibility, exploration of this should be channelled through appropriate research and dissemination strategies. Developing student midwives' understandings of complex ethical positions and their implication in the prevention of harm should also be an implicit component of midwifery curricula.

It is imperative that the academic environment studied considers the value attached to the learning that takes place within it and does not become complacent. For many of the participants their constructions of the *uni* were much less significant to their midwifery identities than those of *practice*. More emphasis should be placed on developing students' understandings as to why *a lot of theory* is important 'midwifery' too. This requires authentic learning reflecting not only current clinical practice in the NHS, but also with an aspiration towards care that is with women and away from the rhetoric of the 'woman-centred' practitioner. Problematically, the NHS is a discursive space that can be challenging to influence, and as such is a powerful determinant of practice and the hegemony therein. The use of the Pinard provides an illustration of how 'practices in an institution or the wider society are

progressively shifted in ways which accord with directions of social change' (Fairclough, 1992, p.9). Over time this loss of the skill relates to its perceived importance (or lack thereof) articulated through the discourses of the mentor and the technocratic imperatives of the employing organisation.

Competence and confidence as properties of identity require a renewed focus. The continued preoccupation with collecting the evidence of an 'accredited witness' (Schostak, 1996, p.9) as part of a long list of skills required to demonstrate 'competence' continues to dominate practice based assessment documents in midwifery. Axiological aspects of competence should therefore be explored in order to extend knowledge for practice. This may also go some way to address the reasons why more midwives are leaving the profession than ever before.

The discourses that relate to midwifery education and practice arise in their socio-political and historical contexts. As such, many entanglements combine from the past into the present and continue to shape the positions that student midwives as subjects can occupy. It is important that midwives in all their professional identities contribute to the knowledge that enables student midwives to appreciate the context of the profession and safeguard its future. The very recent publication of new 'Standards of proficiency for midwives' (NMC, 2019) are suggestive of a shift not towards being with-women, but towards techno-science. This is suggestive of a creep towards, not away from the 'handmaiden' to the doctor described by Bluff and Holloway (2008, p.301). For this reason it is a recommendation that this study has an important contribution to make with regard to future research concerning these new

standards as an aspect of policy, and also of the impact that they will undoubtedly have on the construction and performance of the professional identities of future midwives. I would suggest that the title and the cover alone have a significant story to tell.

Post script - Reflecting on the research process

My overwhelming reflection is that I have changed as a result of the process of doctoral study. Throughout I have tried to focus in the moment, rather than on the end. Getting to the end feels rather odd. I feel that regardless of outcomes which come next, I have achieved success. To have the chance to develop, explore and challenge my own philosophical assumptions and perspectives has been exciting and exhausting (but not in equal measure – more the former than the latter). I regret not having had the foresight (or encouragement and professional steer) earlier in my career to undertake such a project. I did ask a line manager once about doctoral study (almost 20 years ago) and was told not to ask again. Being able to engage with the process on a full-time basis rather than weekends and holidays would perhaps have given a bit more scope for immersion and continuity in both thinking and writing. Despite this, time comes where you find it.

Having the opportunity to initially engage with unlimited philosophical perspectives and theory was not without its problems. The research design and methodology presented me with a number of unpredicted challenges. Curiosity and indecision being the main offenders. I did a lot of reading of theory, possibly taking too much time and going down too many rabbit holes. Despite this, I eventually managed to figure out what I wanted to do, how I wanted to do it and with whom (both theoretically and figuratively).

Recruitment to the empirical part of the study was difficult because I didn't want to overstate my position as a researcher on account of being the Bachelor of Midwifery Programme Leader at the time. Being a research student, but also as

a programme leader was problematic and I was very tentative with my recruitment strategy. I now understand that there are huge sensitivities involved for people when proposing filming as a method of data collection and that trust forms a significant element of the developing relationship in the research process.

I naïvely assumed that from a generational perspective I was dealing with 'digital natives' in the visual arena, but it turns out that the digital 'native' is a fallacy and digital competence and confidence cannot be universally ascribed. Despite this, I loved using the iPad and working with the images, and feel I have been able to construct a little creative subject position of my own. Whether I would have felt comfortable with my supervisors recording me learning about 'comma-splices' (a frequent-flyer in my repertoire of grammatical errors) or presenting at a doctoral conference, for the purposes of analysis is questionable.

I learned that what is taken-for-granted by the researcher in the research process could provoke completely different responses for the participants. Participant 5, whose path to becoming a midwife was disrupted by my questioning of midwifery identity in the research flyer, and who chose not to practice after qualification provides just such an example. Her tearful arrival at the door of the simulation room and our subsequent discussion provided a space for her to acknowledge some of her own anxieties around the professional identities of midwives. Serendipitously, I received an email from her recently having communicated with her only once since 2016. She commented (with consent to use)

> I don't know how well you'll remember me but I was in the cohort that graduated in 2016. I was one of the third years that came in to help you with your research and ended up all upset with doubts about my future. You have no idea how much I appreciate your time, kind words and support that you gave me that day. I think about it often as it has helped me shape the way I work as a doula[20].

Having worked with her data all the while, I have felt her presence close at hand and remember her well and fondly. At the time, her doubts about the ways in which midwives and women experience 'midwifery' led her to practice as a doula rather than a midwife. It is evident that contrary to my expectations of the encounter with the student at the door, my flyer provoked something that may or may not have eventually happened. It is something that I will carry forwards, both as a researcher and hopefully as a supervisor of researchers.

Prior to commencing my studies I was advised by a senior academic in my University that 'educational research wasn't a priority for the University' and that I would be wasting my time pursuing what they felt to be a 'vanity project'. Clinical research was proposed as the only credible path (and the only one that the University would support) as it would have 'impact' and be 'REFable'. I had been a midwifery educator for fourteen years at the time, and very much felt that educational research was a priority for not only my practice, but to enhance the experiences of the students that I teach. I felt that philosophy could help me understand practice in all its forms, far better than practice would help me

[20] A 'doula' is a paid birth attendant who provides only psychosocial care and support. They are responsible and accountable only to the woman for the care given, are usually self-employed and would not participate in 'midwifery' practices.

understand philosophy. It was important to have ownership of the experience and to have confidence in the confidentiality of my studies that may not have been possible in my own institution. I can say with certainty that I feel I made all the right choices, but the most important choice was made for me, that of my supervisors. Both of whom have enabled me to have the extraordinary experience that I have.

References

Akrich, M. and Pasveer, B. (2004) 'Embodiment and Disembodiment in Childbirth Narratives', *Body & Society*, 10(2–3), pp. 63–84. Available: doi: 10.1177/1357034X04042935.

Althusser, L. (2000) 'Ideology interpellates individuals as subjects', in du Gay, P., Evans, J., and Redman, P. (eds) *Identity: a reader*. Los Angeles : London: SAGE in association with the Open University (Identity: a reader).

Armstrong, N. (2010) 'Clinical mentors' influence on student midwives' clinical practice', *British Journal of Midwifery*, 18(2), pp. 114–123. Available at: https://login.ezproxy.napier.ac.uk/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=105122055&site=ehost-live.

Bäck, L. *et al.* (2017) 'Developing competence and confidence in midwifery-focus groups with Swedish midwives', *Women and Birth*. Elsevier, 30(1), pp. e32–e38. Available: doi: 10.1016/j.wombi.2016.08.004.

Baird, K. (2007) 'Exploring autonomy in education: preparing student midwives', *British Journal of Midwifery*, 15(7), pp. 400–405. Available: doi: 10.12968/bjom.2007.15.7.23788.

Ball, S. J. (1993) 'What is policy? Texts, trajectories and toolboxes', *Discourse: Studies in the Cultural Politics of Education*, 13(2), pp. 10–17. Available: doi: 10.1080/0159630930130203.

Ball, S. J. (2013) *Foucault, power and education*. London: Routledge.

Ball, S. J. (2015) ‘What is policy? 21 years later: reflections on the possibilities of policy research’, *Discourse*. Routledge, 36(3), pp. 306–313. Available: doi: 10.1080/01596306.2015.1015279.

Bamberg, M. (1997) ‘Positioning Between Structure and Performance’, *Journal of Narrative and Life History*. John Benjamins Publishing Company, 7(1–4), pp. 335–342. Available: doi: 10.1075/jnlh.7.42pos.

Bamberg, M. (2005) ‘Narrative discourse and identities’, in Kindt, T. (ed.). New York: Walter de Gruyter (Narratology beyond literary criticism: Mediality - disciplinarity), pp. 213–237.

Bamberg, M. *et al.* (2011) ‘Discourse and Identity Construction’, in Fina, A. De, Schiffrin, D., and Bamberg, M. (eds) *Handbook of Identity Theory and Research*. New York: Springer (Handbook of Identity Theory and Research), pp. 3–24. Available: doi: 10.1007/978-1-4419-7988-9_8.

Bamberg, M., DeFina, A. and Schiffrin, D. (2011) ‘Discourse and Identity Construction’, in Schwartz, S. J., Luyckx, K., and Vignoles, V. L. (eds). *Handbook of Identity Theory and Research* New York: Springer.

Bamberg, M., De Fina, A. and Schiffrin, D. (2011) ‘Discourse and Identity Construction’, in *Handbook of Identity Theory and Research*. Springer New York, pp. 177–199. Available: doi: 10.1007/978-1-4419-7988-9_8.

Bamberg, M. and Georgakopoulou, A. (2008) ‘Small stories as a new perspective in narrative and identity analysis’, *Text & Talk*, 28(3). Available: doi: 10.1515/TEXT.2008.018.

Barker Caza, B. and Creary, S. (2016) 'The construction of professional identity', in *Perspectives on Contemporary Professional Work*. Available: doi: 10.4337/9781783475582.00022.

Barnfather, T. (2013) 'Can intuitive knowledge be taught in midwifery practice?', *British Journal of Midwifery*. MA Healthcare Ltd, 21(2), pp. 131–136. Available: doi: 10.12968/bjom.2013.21.2.131.

Bassett, K. (1996) 'Anthropology, clinical pathology and the electronic fetal monitor: Lessons from the heart', *Social Science and Medicine*, 42(2), pp. 281–292. Available: doi: 10.1016/0277-9536(95)00101-8.

Bauman, R. (2004) *A world of others' words. Cross cultural perspectives on intertextuality.* Oxford: Blackwell.

Beaumont, E. *et al.* (2016) 'Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey', *Midwifery*. Churchill Livingstone, 34, pp. 239–244. Available: doi: 10.1016/j.midw.2015.11.002.

Beck, U. (1996) 'World Risk Society as Cosmopolitan Society?: Ecological Questions in a Framework of Manufactured Uncertainties', *Theory, Culture & Society*, 13(4), pp. 1–32. Available: doi: 10.1177/0263276496013004001.

Bedford, H. *et al.* (1993) 'Assessing Competencies in Nursing and Midwifery Education. Final Report.' ERIC.

Benoit, C. (1989) 'The professional socialisation of midwives: Balancing art and

science', *Sociology of Health & Illness*. John Wiley & Sons, Ltd (10.1111), 11(2), pp. 160–180. Available: doi: 10.1111/1467-9566.ep10844338.

BERA (2018) *Ethical Guidelines for Educational Research, fourth edition (2018) | BERA*. Available at: https://www.bera.ac.uk/publication/ethical-guidelines-for-educational-research-2018-online (Accessed: 22 June 2020).

Bezemer, J. and Mavers, D. (2011) 'Multimodal transcription as academic practice: A social semiotic perspective', *International Journal of Social Research Methodology*, 14(3), p. 191. Available: doi: 10.1080/13645579.2011.563616.

Blake, D. (2008) 'Pinards: out of use and out of date?', *British Journal of Midwifery*. MA Healthcare London, 16(6), pp. 364–365.

Bluff, R. and Holloway, I. (2008) 'The efficacy of midwifery role models', *Midwifery*, 24(3), pp. 301–309. Available: doi: 10.1016/j.midw.2005.02.008.

Bourke, T., Ryan, M. E. and Lidstone, J. (2013) 'Reflexive professionalism: reclaiming the voice of authority in shaping the discourses of education policy', *Asia-Pacific Journal of Teacher Education*, 41(4), pp. 398–413. Available: doi: 10.1080/1359866X.2013.838619.

Bucholtz, M. (2000) 'The politics of transcription', *Journal of Pragmatics*, 32(10), pp. 1439–1465. Available: doi: //doi.org/10.1016/S0378-2166(99)00094-6.

Bucholtz, M. (2007) 'Variation in transcription', *Discourse Studies*, 9(6), pp. 784–808. Available: doi: 10.1177/1461445607082580.

Bucholtz, M. and Hall, K. (2005) 'Identity and interaction: A sociocultural

linguistic approach', *Discourse Studies*, 7(4–5), pp. 585–614. Available: doi: 10.1177/1461445605054407.

Butler, J. (1993) *Bodies that matter: On the discursive limits of sex*. London: Routledge.

Butler, J. (2011) *Gender trouble: Feminism and the subversion of identity*, *Gender Trouble: Feminism and the Subversion of Identity*. Routledge. Available: doi: 10.4324/9780203824979.

Byrom, S. and Downe, S. (2010) '"She sort of shines": midwives' accounts of "good" midwifery and "good" leadership', *Midwifery*, 26(1), pp. 126–137. Available: doi: 10.1016/j.midw.2008.01.011.

Cahill, H. A. (2001) 'Male appropriation and medicalization of childbirth: an historical analysis', *Journal of advanced nursing*. Wiley Online Library, 33(3), pp. 334–342.

Cassell, J. and McNeill, D. (1991) 'Gesture and the poetics of prose', *Poetics Today*. JSTOR, 12(3), pp. 375–404.

Cetina, K. K., Schatzki, T. R. and Von Savigny, E. (2005) *The practice turn in contemporary theory*. Routledge.

Charles, S. (2012) 'Coming to life: Philosophies of pregnancy, childbirth and mothering', in LaChance Adams, S. and Lundquist, C. R. (eds) *Coming to Life: Philosophies of Pregnancy, Childbirth and Mothering*. Fordham Scholarship Online, pp. 1–401. Available: doi: 10.5422/fordham/9780823244607.001.0001.

Chenery-Morris, S. (2015) 'The importance of continuity of mentorship in pre-

registration midwifery education', *Evidence Based Midwifery*, 13(2).

Chief Nursing Officers of England Northern Ireland Scotland and Wales (2010) *Midwifery 2020: Delivering Expectations.* London.

Clews, C. (2013) 'Normal birth and its meaning: a discussion paper', *Evidence Based Midwifery*, 11(1), pp. 16–20.

Clohessy, N., McKellar, L. and Fleet, J. (2019) 'Bounce back- bounce forward: Midwifery students experience of resilience', *Nurse Education in Practice*. Available: doi: 10.1016/j.nepr.2019.04.011.

Cody, L. F. (1999) 'The Politics of Reproduction: From Midwives' Alternative Public Sphere to the Public Spectacle of Man-Midwifery', *Eighteenth-Century Studies*, 32(4), pp. 477–495. Available at: http://www.jstor.org/stable/30053929.

Coffey, F. (2015) 'Learning by simulation–is it a useful tool for midwifery education', *New Zealand College of Midwives Journal*. New Zealand College of Midwives, 51, pp. 30–36.

Coldridge, L. and Davies, S. (2017) '"Am I too emotional for this job?" An exploration of student midwives' experiences of coping with traumatic events in the labour ward', *Midwifery*. Available: doi: 10.1016/j.midw.2016.11.008.

Collington, V. *et al.* (2012) 'Supporting the midwifery practice-based curriculum: the role of the link lecturer', *Nurse education today*. Elsevier, 32(8), pp. 924–929.

Copland, F. *et al.* (2015) *Linguistic ethnography: collecting, analysing and presenting data*. Los Angeles: Sage. Available at:

http://ezproxy.stir.ac.uk/login?url=http://methods.sagepub.com/book/linguistic-ethnography.

Coxon, K. *et al.* (2016) 'Reconceptualising risk in childbirth', *Midwifery*. Churchill Livingstone, 38, pp. 1–5. Available: doi: 10.1016/J.MIDW.2016.05.012.

Coxon, K., Sandall, J. and Fulop, N. J. (2014) 'To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions', *Health, Risk and Society*. 16(1), pp. 51–67. Available: doi: 10.1080/13698575.2013.859231.

Crowther, S. *et al.* (2016) 'Sustainability and resilience in midwifery: A discussion paper', *Midwifery*, 40, pp. 40–48. Available: doi: 10.1016/j.midw.2016.06.005.

Dalmiya, V. and Alcoff, L. (1993) 'Are "Old Wives" Tales' Justified?', *Feminist epistemologies*. Routledge New York, 1993, pp. 217–244.

Davies, B. and Harré, R. (1990) 'Positioning: The Discursive Production of Selves', *Journal for the Theory of Social Behaviour*, 20(1), pp. 43–63. Available: doi: 10.1111/j.1468-5914.1990.tb00174.x.

Davies, S. and Coldridge, L. (2015a) '"No Man's Land": An exploration of the traumatic experiences of student midwives in practice', *Midwifery*, 31(9), pp. 858–864. Available: doi: 10.1016/j.midw.2015.05.001.

Davies, S. and Coldridge, L. (2015b) '"No Man's Land": An exploration of the traumatic experiences of student midwives in practice', *Midwifery*, 31(9), pp. 858–864. Available: doi: //doi.org/10.1016/j.midw.2015.05.001.

Davis-Floyd, R. (2007) ‘Daughter of time: the postmodern midwife (Part 1)’, *Revista da Escola de Enfermagem da USP*. SciELO Brasil, 41(4), pp. 705–710.

Davis-Floyd, R. and Davis, E. (2018) ‘Intuition as Authoritative Knowledge in Midwifery and Homebirth’, *Medical Anthropology Quarterly*, 10(2), pp. 237–269. Available at: http://www.jstor.org/stable/649330.

Davis-Floyd, R. E. and Sargent, C. F. (1997) *Childbirth and authoritative knowledge: Cross-cultural perspectives*. Univ of California Press.

Davis-Floyd, R., Pigg, S. L. and Cosminsky, S. (2001) ‘Introduction. Daughters of time: the shifting identities of contemporary midwives.’, *Medical anthropology*, 20(2–3), pp. 105–139. Available: doi: 10.1080/01459740.2001.9966192.

Davis-Floyd, R., Pigg, S. L. and Cosminsky, S. (2001) ‘Introduction. Daughters of time: The shifting identities of contemporary midwives’, *Medical Anthropology*, 20(2–3), pp. 105–139. Available: doi: 10.1080/01459740.2001.9966192.

Davis, B. and Harré, R. (1990) ‘Positioning: The social construction of selves’.

Denzin, N. K. and Lincoln, Y. S. (2013) ‘The landscape of qualitative research (ed.). Tousand Oaks’. California, USA: SAGE.

Divall, B. (2014) *Heads above the Parapet: Identity construction and enactment in midwifery leadership*. Unpublished thesis: University of Warwick.

Divall, B. (2018) ‘Competing discourses of risk and woman-centred care: challenges for midwives and women’, *International Journal of Birth and Parent*

Education.

Dreyfus, H. L. and Rabinow, P. (2014) *Michel Foucault: Beyond structuralism and hermeneutics*, *Michel Foucault: Beyond Structuralism and Hermeneutics*. Taylor and Francis. Available: doi: 10.4324/9781315835259.

Edinburgh Napier University (2015) *Academic regulations*. Available at: https://staff.napier.ac.uk/services/dlte/Regulations/Pages/Regulations.aspx.

Education, Q. A. A. for H. and Scotland, N. H. S. E. for (2009) *Scottish subject benchmark statement: midwifery*. Gloucester: Quality Assurance Agency for Higher Education. Available at: http://www.qaa.ac.uk/crntwork/benchmark/scot/midwifery.pdf.

Edwards, D. (2005) 'Discursive psychology', *Handbook of language and social interaction*. Taylor and Francis, pp. 257–273. Available: doi: 10.4324/9780429356032-4.

Einion, A. (2016) 'Resilience, midwifery and professional identity: changing the script of midwifery culture through narrative. Part 1.', *The practising midwife*, 19(6), pp. 30–32. Available at: https://login.ezproxy.napier.ac.uk/login?qurl=https%3A%2F%2Fsearch.proquest.com%2Fdocview%2F1807080834%3Faccountid%3D16607.

Eraut, M. (1994) *Developing Professional Knowledge And Competence*. London ; Washington, D.C: Routledge.

Erickson, F. (2004) 'Demystifying Data Construction and Analysis', *Anthropology & Education Quarterly*, 35(4), pp. 486–493. Available: doi:

10.1525/aeq.2004.35.4.486.

Etzioni, A. (1969) *The Semi-Professions and their Organization*. New York: Free Press.

Evans, J. *et al.* (2018) 'The future in their hands: Graduating student midwives' plans, job satisfaction and the desire to work in midwifery continuity of care', *Women and Birth*. Available: doi: 10.1016/j.wombi.2018.11.011.

Evetts, J. (2003) 'The sociological analysis of professionalism: Occupational change in the modern world', *International Sociology*, 18(2), pp. 395–415. Available: doi: 10.1177/0268580903018002005.

Fairclough, N. (1992) *Discourse and social change*. Cambridge: Polity Press.

Fairclough, N. *et al.* (2009) *Methods for Critical Discourse Analysis*, *Educational Philosophy and Theory*. Los Angeles: SAGE. Available: doi: 10.1111/j.1469-5812.2010.00698.x.

Fairclough, N. (2010) *Critical Discourse Analysis: The Critical Study of Language*. London: Longman.

Fenwick, T. (2016) *Professional Responsibility and Professionalism*. London: Routledge.

Fenwick, T. J. and Nerland, M. (2014) *Reconceptualising Professional Learning : Sociomaterial Knowledges, Practices and Responsibilities*, *Reconceptualising Professional Learning: Sociomaterial Knowledges, Practices and Responsibilities*. Hoboken: Routledge. Available: doi: 10.4324/9781315813714.

Fenwick, T., Nerland, M. and Jensen, K. (2012) 'Sociomaterial approaches to conceptualising professional learning and practice', *Journal of Education and Work*, 25(1), pp. 1–13. Available: doi: 10.1080/13639080.2012.644901.

Fenwick, T., Zukas, M. and Kilminster, S. (2013) 'Understanding transitions in professional practice and learning', *Journal of Workplace Learning*. Emerald Group Publishing Limited.

Finlay, S. and Sandall, J. (2009) '"Someone's rooting for you": Continuity, advocacy and street-level bureaucracy in UK maternal healthcare', *Social Science & Medicine*. Pergamon, 69(8), pp. 1228–1235. Available: doi: 10.1016/J.SOCSCIMED.2009.07.029.

Fisher, M. *et al.* (2017) 'A scoping study to explore the application and impact of grading practice in pre-registration midwifery programmes across the United Kingdom', *Nurse Education in Practice*.

Foley, L. and Faircloth, C. A. (2003) 'Medicine as discursive resource: legitimation in the work narratives of midwives', *Sociology of Health & Illness*. Wiley Online Library, 25(2), pp. 165–184.

Fontein-Kuipers, Y., de Groot, R. and van Staa, A. (2018) 'Woman-centered care 2.0: Bringing the concept into focus', *European journal of Midwifery*, 2(5).

Foucault, M. (1972) *The Archaeology of Knowlege*. London: Tavistock.

Foucault, M. (1979) *Discipline and punish: the birth of the prison*. Harmondsworth: Penguin.

Foucault, M (1984) *The order of discourse*. Edited by M. Shapiro. Oxford:

Blackwell.

Foucault, Michel (1984) ‘Why study power: the question of the subject’, in Rabinow, P. (ed.) *The Foucault Reader*. London: Peregrine.

Foucault, M. (1988) *Practicing Criticism*, *Politics, Philosophy, Culture: Interviews and Other Writings, 1977-1984*.

Foucault, M. and Kritzman, L. D. (1988) ‘Practising criticism (trans. A. Sheridan)’, *Michel Foucault: Politics, Philosophy, Culture*, pp. 1977–1984.

Fraser, D. M. *et al.* (2013) ‘The MINT project—An evaluation of the impact of midwife teachers on the outcomes of pre-registration midwifery education in the UK’, *Midwifery*. Elsevier, 29(1), pp. 86–94.

Fry, J., Rawnson, S. and Lewis, P. (2008) ‘Student caseloading: preparing and supporting students’, *British Journal of Midwifery*. MA Healthcare London, 16(9), pp. 568–573.

Fullerton, J. T. *et al.* (2013) ‘Competency-based education: The essential basis of pre-service education for the professional midwifery workforce’, *Midwifery*. Elsevier, 29(10), pp. 1129–1136. Available: doi: 10.1016/j.midw.2013.07.006.

Du Gay, P. (2007) *Organizing identity: Persons and organizations after theory*. Los Angeles : London: Sage.

Gee, J. P. (2014) *An introduction to discourse analysis: theory and method*. 4th edn. London ; New York, NY: Routledge.

Georgakopoulou, A. (2015) ‘Small Stories Research’, in De Fina, A.,

Georgakopoulou, A. (ed.) *The Handbook of Narrative Analysis*. John Wiley & Sons, Ltd, pp. 255–271. Available: doi: 10.1002/9781118458204.ch13.

Giddens, A. (1991) *Modernity and self-identity: Self and society in the late modern age*. California: Stanford University Press.

Glezerman, M. (2012) 'Planned vaginal breech delivery: Current status and the need to reconsider', *Expert Review of Obstetrics and Gynecology*, 7(2), pp. 159–166. Available: doi: 10.1586/eog.12.2.

Goffman, E. (1978) *The presentation of self in everyday life*. Harmondsworth London.

GTCS (2012) *The standards for registration: mandatory requirements for registration with the general teaching council for Scotland*, *Edinburgh: GTC Scotland*. Edinburgh.

Guba, E. (1990) *The paradigm dialog.* California: Sage.

Gumperz, J. and Berenz, N. (1993) 'Transcribing conversational exchanges
', in Edwards, J. and Lampert, M. (eds). Hillsdale: Erlbaum (Talking data: Transcription and coding in discourse research), pp. 91–121.

Hager, P., Lee, A. and Reich, A. (2012) *Practice, learning and change: Practice-theory perspectives on professional learning*. Springer Science & Business Media.

Hall, S., Evans, J. and Nixon, S. (2013) *Representation / edited by Stuart Hall, Jessie Evans and Sean Nixon.* London; Thousand Oaks, Calif.; Milton Keynes, U.K.: Sage Publications ; Open University.

Hamilton, V., Baird, K. and Fenwick, J. (2019) 'Nurturing autonomy in student midwives within a student led antenatal clinic', *Women and Birth*. Available: doi: https://doi.org/10.1016/j.wombi.2019.12.001.

Hannah, M. E. *et al.* (2000) 'Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. Term Breech Trial Collaborative Group.', *Lancet (London, England)*. England: Elsevier Limited, 356(9239), pp. 1375–1383. Available: doi: 10.1016/s0140-6736(00)02840-3.

ten Have, P. (2011) *Doing Conversation Analysis*. 2nd edn. California: SAGE.

Hazel, S. (2015) 'The paradox from within: research participants doing-being-observed', *Qualitative Research*, 16(446–467). Available: doi: 10.1177/1468794115596216.

Heagerty, B. V (1997) 'Willing handmaidens of science? The struggle over the new midwife in early twentieth-century England', *Reflections on Midwifery*. London, Bailliere Tindall, pp. 70–95.

Healy, S. *et al.* (2018) 'Preparing student midwives for professional practice: Evaluation of a student e-portfolio assessment item.', *Midwifery*. Faculty of Health and Life Sciences, University of the West of England, Glenside Campus, Blackberry Hill, Bristol BS16 1DD, UK. katherine.pollard@uwe.ac.uk: Churchill Livingstone, 30(5), pp. 612–619. Available: doi: 10.1016/j.midw.2018.04.020.

Healy, S., Humphreys, E. and Kennedy, C. (2016) 'Midwives' and obstetricians' perceptions of risk and its impact on clinical practice and decision-making in labour: An integrative review', *Women and Birth*. Elsevier, 29(2), pp. 107–116.

Available: doi: 10.1016/J.WOMBI.2015.08.010.

Heath, C., Hindmarsh, J. and Luff, P. (2010) *Video in qualitative research: analysing social interaction in everyday life*. Los Angeles: SAGE.

Hindley, C. and Thomson, A. M. (2007) 'Intrapartum fetal monitoring and the spectre of litigation: A qualitative study of midwives' views', *Clinical Governance*, 12(4), pp. 233–243. Available: doi: 10.1108/14777270710828900.

Hochschild, A. R. (2013) *The managed heart : commercialization of human feeling*. Updated wi. Edited by VLeBooks. Place of publication not identified]: Place of publication not identified : VLeBooks.

Holland, K., Middleton, L. and Uys, L. (2012) 'Professional confidence: A concept analysis.', *Scandinavian Journal of Occupational Therapy*, 19(2), pp. 214–224. Available: doi: 10.3109/11038128.2011.583939.

Holmes, J., Schnurr, S. and Marra, M. (2007) 'Leadership and communication: discursive evidence of a workplace culture change', *Discourse & Communication*, 1(4), pp. 433–451. Available: doi: 10.1177/1750481307082207.

Holstein, J. A. and Gubrium, J. F. (2013) 'The Constructionist Analytics of Interpretive Practice', in Denzin, N. and Lincoln, Y. (eds). Los Angeles: Sage (Strategies of Qualitative Inquiry), pp. 253–289.

Hughes, A. J. and Fraser, D. M. (2011) '"'There are guiding hands and there are controlling hands'": Student midwives experience of mentorship in the UK', *Midwifery*, 27, pp. 477–483. Available: doi: 10.1016/j.midw.2010.03.006.

Humes, W. and Bryce, T. (2003) ‘Post-structuralism and policy research in education’, *Journal of Education Policy*, 18(2), pp. 175–187.

Humes, W. M. (1997) ‘Analysing the policy process’, *Scottish Educational Review*, 29, pp. 20–29.

Hunter, B. *et al.* (2008) ‘Relationships: the hidden threads in the tapestry of maternity care’, *Midwifery*. Elsevier, 24(2), pp. 132–137.

Hunter, B. *et al.* (2019) ‘Midwives in the United Kingdom: Levels of burnout, depression, anxiety and stress and associated predictors’, *Midwifery*, 79, p. 102526. Available: doi: https://doi.org/10.1016/j.midw.2019.08.008.

Hunter, B. and Warren, L. (2013) *Investigating Resilience in Midwifery: Final report*, *Cardiff University*.

Hunter, B. and Warren, L. (2014) ‘Midwives experiences of workplace resilience’, *Midwifery*. Available: doi: 10.1016/j.midw.2014.03.010.

Impey, LWM., Murphy, DJ., Griffiths, M., Penna, LK., on behalf of the R. (2017) ‘Management of Breech Presentation: Green-top Guideline No. 20b’, *BJOG: An International Journal of Obstetrics and Gynaecology*, 124(7), pp. e151–e177. Available: doi: 10.1111/1471-0528.14465.

Jäger, S. and Maier, F. (2009) ‘Theoretical and Methodological Aspects of Foucauldian Critical Discourse Analysis and Dispositive Analysis’, in Wodak, R. and Meyer, M. (eds). London: Sage (Methods of Critical Discourse Analysis), pp. 34–61.

Janney, R. W. (1999) ‘Words as gestures’, *Journal of Pragmatics*, 31(7), pp.

953–972. Available: doi: https://doi.org/10.1016/S0378-2166(98)00102-7.

Jefferson, G. (1989) ‘Preliminary notes on a possible metric which provides for a’standard maximum’silence of approximately one second in conversation.’, in Roger, D. and Bull, P. (eds) *Conversation: an interdisciplinary perspective*. Clevedon: Multilingual Matters, pp. 156–197.

Jørgensen, M. and Phillips, L. (2002) *Discourse Analysis as Theory and Method*, *Discourse Analysis as Theory and Method*. London: SAGE Publications Ltd. Available: doi: 10.4135/9781849208871.

Kirkup, B. (2015) *The report of the Morecambe Bay Investigation : an independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January* . London]: London : Stationery Office.

Knight, M. *et al.* (2019) *Saving Lives, Improving Mother’s Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17*, *(Eds.) on behalf of MBRRACE-UK*.

Laclau, E. and Mouffe, C. (2015) *Hegemony and Socialist Strategy: Towards a Radical Democratic Politics*. 3rd edn. London: Verso.

Landry, D. and MacLean, G. (1990) ‘Of Forceps, Patents, and Paternity: Tristram Shandy’, *Eighteenth-Century Studies*, 23(4), pp. 522–543. Available: doi: 10.2307/2739183.

Lawler, S. (2015) *Identity : sociological perspectives*. Second edi. Edited by VLeBooks. Place of publication not identified]: Place of publication not identified : VLeBooks.

Lazzarato, M. (2009) 'Neoliberalism in Action: Inequality, Insecurity and the Reconstitution of the Social', *Theory, Culture & Society*. Available: doi: 10.1177/0263276409350283.

Lendahls, L. and Oscarsson, M. G. (2017) 'Midwifery students' experiences of simulation- and skills training', *Nurse Education Today*, 50. Available: doi: 10.1016/j.nedt.2016.12.005.

Lepisto, D. A., Crosina, E. and Pratt, M. G. (2015) 'Identity Work within and beyond the Professions: Toward a Theoretical Integration and Extension', in Costa, A., Silva, E., and Aparicio, M. (eds) *International Handbook of Professional Identitites*. Rosemead: Scientific and Academic Publishing, pp. 11–37.

Licqurish, S. and Seibold, C. (2013) '"Chasing the numbers": Australian Bachelor of Midwifery students' experiences of achieving midwifery practice requirements for registration', *Midwifery*. Available: doi: 10.1016/j.midw.2012.06.006.

Lipsky, M. (1980) *Street-level bureaucracy: Dilemmas of the individual in public service*. New York: Russell Sage Foundation.

Longworth, M. K. (2013) 'An exploration of the perceived factors that affect the learning and transfer of skills taught to student midwives', *Midwifery*. Elsevier, 29(8), pp. 831–837.

Luce, A. *et al.* (2016) '"Is it realistic?" the portrayal of pregnancy and childbirth in the media', *BMC Pregnancy and Childbirth*, 16(1), p. 40. Available: doi: 10.1186/s12884-016-0827-x.

Luff, P. and Heath, C. (2015) 'Transcribing Embodied Action', in. John Wiley & Sons, Inc. *The Handbook of Discourse Analysis*, pp. 367–390. Available: doi: 10.1002/9781118584194.ch17.

MacDonald, K. M. (1995) *The Sociology of the Professions*. London: Sage.

Macdonald, S. and Johnson, G. (2017) *Mayes' Midwifery*. 15th ed. United Kingdom: Dawson Books.

Malins, E. (1901) 'An Address on Midwifery and Midwives: Delivered at the Annual Meeting of the Birmingham and Midland Counties Branch of the British Medical Association, June 13th, 1901', *British Medical Journal*. BMJ Publishing Group, 1(2112), p. 1529.

Mander, R. (2009) 'The academic midwife', in *Becoming a Midwife*, pp. 105–114. Available: doi: 10.4324/9780203871416.

Mander, R. and Murphy-Lawless, J. (2013) *The politics of maternity*. London: Routledge.

McIntosh, T. *et al.* (2013) 'Final year students' perceptions of learning to be a midwife in six British universities', *Nurse Education Today*. Churchill Livingstone, 33(10), pp. 1179–1183. Available: doi: 10.1016/J.NEDT.2012.05.020.

McKinnon, K. (2016) 'The geopolitics of birth', *Area*. Blackwell Publishing Ltd,

48(3), pp. 285–291. Available: doi: 10.1111/area.12131.

Mcluckie, C. and McHugh, N. (2013) ‘Pandora’s Box: how to humanise educational technology to ensure an emotionally fluent midwifery programme - recognising the issues.’ *Midirs Midwifery Digest.* 23(1):17-21

Merton, R. K. (1947) ‘The Machine, the Worker, and the Engineer’, *Science*, 105(2717), pp. 79–84. Available: doi: 10.1126/science.105.2717.79.

Myles, M. (1975) *Textbook for Midwives*. 8th edn. Edinburgh: Churchill Livingstone.

Nel, S. and Geraghty, S. (2018) ‘Are midwifery students adequately prepared for vaginal breech birth in clinical practice?’, *British Journal of Midwifery*. London, 26(3), pp. 145–149. Available: doi: 10.12968/bjom.2018.26.3.145.

Newnham, E. and Kirkham, M. (2019) ‘Beyond autonomy: Care ethics for midwifery and the humanization of birth’, *Nursing Ethics*, p. 969733018819119. Available: doi: 10.1177/0969733018819119.

NHS Inform (2021) *NHS Inform*, *Ready Steady Baby*. Available at: https://www.nhsinform.scot/ready-steady-baby/labour-and-birth/getting-ready-for-the-birth/your-birth-plan (Accessed: 26 January 2021).

NHS Quality Improvement Scotland (2009) *Pathways for Maternity Care*. Available at: http://www.healthcareimprovementscotland.org/previous_resources/implementation_support/keeping_childbirth_natural__d.aspx.

NICE (2017) ‘Antenatal care for uncomplicated pregnancies | Guidance and

guidelines | NICE', *NICE guidelines uncomplicated pregnancies*. Available: doi: 10.1159/000201106.

Nicolini, D. and Roe, B. (2014) 'Surfacing the multiple. Diffractive methods for rethinking professional practice and knowledge', *Reconceptualising Professional Learning. edn. Edited by Fenwick T, Nerland M: Routledge*. Taylor and Francis, pp. 67–82. Available: doi: 10.4324/9781315813714.

NMC (2009) 'Standards for Pre-registration midwifery education'. London: Nursing and Midwifery Council.

NMC (2015) 'Review of midwifery regulation in the United Kingdom'. London: Nursing and Midwifery Council.

NMC (2017) 'Practising as a Midwife in the UK: An overview of midwifery regulation'. London: Nursing and Midwifery Council.

NMC (2018) 'The Nursing and Midwifery Council's response to the Government Equality Office's consultation on reform of the Gender Recognition Act 2004 About us The GRA in the context of professional regulation Nursing and Midwifery Council'. London: Nursing and Midwifery Council.

NMC (2019) 'Standards of proficiency for midwives'. London: Nursing and Midwifery Council. Available at: www.nmc.org.ukStandardsofproficiencyformidwives1 (Accessed: 19 June 2020).

NMC (2020a) 'Members of Council', *Nursing and Midwifery Council - about us*. London: Nursing and Midwifery Council. Available at:

https://www.nmc.org.uk/about-us/governance/the-council/members-of-council/ (Accessed: 18 June 2020).

NMC (2020b) ‘Mid-year update’. London: Nursing and Midwifery Council. Available at: www.nmc.org.uk (Accessed: 18 June 2020).

NMC (2020c) ‘Nursing and Midwifery Council - Annual Report 2019’. London: Nursing and Midwifery Council.

Nolan, Y. (2017) ‘Leadership, autonomy and the newly qualified midwife’, *MIDIRS Midwifery Digest*, 27(4), pp. 441–443.

Nursing and Midwifery Council (2010) ‘Standards for pre-registration nursing education’, *Nursing and Midwifery Council*. London: Nursing and Midwifery Council.

Nursing and Midwifery Council (2018) ‘Annual equality, diversity and inclusion report’. London: Nursing and Midwifery Council. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/edi/annual-edi-report-2018-2019-final.pdf (Accessed: 23 June 2020).

Oates, J. *et al.* (2019) ‘The mental health and wellbeing of midwifery students: An integrative review’, *Midwifery*, pp. 80–89. Available: doi: //doi.org/10.1016/j.midw.2019.02.007 ".

Ockenden, D. (2020) *Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*. Available at: https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf.

Ozga (1990) ‘Policy Research and Policy Theory: a comment of Fitz and Halpin’, *Journal of Education Policy*. 5(4), pp. 359–362.

Passmore, H. and Chenery-Morris, S. (2014) ‘Exploring the value of the tripartite assessment of students in pre-registration midwifery education: A review of the evidence’, *Nurse Education in Practice*. Churchill Livingstone, 14(1), pp. 92–97. Available: doi: 10.1016/J.NEPR.2013.06.008.

Pauwels, L. (2010) ‘Visual Sociology Reframed: An Analytical Synthesis and Discussion of Visual Methods in Social and Cultural Research’, *Sociological Methods & Research*, 38(4), pp. 545–581. Available: doi: 10.1177/0049124110366233.

Peace, M. (2012) ‘Enquiry-based learning in midwifery: The lecturer’s experience’, *British Journal of Midwifery*. MA Healthcare London, 20(5), pp. 361–368.

Pink, S. (2012) *Advances in Visual Methodology*. Los Angeles: SAGE Publications Ltd.

Pink, S. (2013) *Doing Visual Ethnography*. 3rd edn. Los Angeles: Sage Publications Ltd.

Plested, M. and Kirkham, M. (2016) ‘Risk and fear in the lived experience of birth without a midwife’, *Midwifery*. Churchill Livingstone, 38, pp. 29–34. Available: doi: 10.1016/J.MIDW.2016.02.009.

Preston, S. and Aslett, J. (2014) ‘Resisting neoliberalism from within the academy: Subversion through an activist pedagogy’, *Social work education*.

Taylor & Francis, 33(4), pp. 502–518.

PSA (2016) *Professional identities and regulation: a Literature Review*, *Professional Standards Authority for Health and Social Care*. London.

Rajchman, J. (1988) 'Foucault's Art of Seeing', *October*, 44(88), pp. 89–117. Available: doi: 10.2307/778976.

Rawnson, S. *et al.* (2009) 'Student midwives' views of caseloading: the BUMP study', *British Journal of Midwifery*. MA Healthcare London, 17(8), pp. 484–489.

Rawnson, S., Fry, J. and Lewis, P. (2008) 'Student caseloading: embedding the concept within education', *British Journal of Midwifery*. MA Healthcare London, 16(10), pp. 636–641.

RCM/RCOG (2017) 'Consensus statement on Electronic Fetal Monitoring (EFM)'. Available at: https://www.rcm.org.uk/sites/default/files/RCMRCOG Consensus Statement on EFM A4_3_0.pdf.

RCM (2012) *Evidence Based Guidelines for Midwifery-Led Care in Labour Intermittent Auscultation (IA)*. London.

RCM (2015) 'Review of midwifery regulation by the Nursing and Midwifery Council (NMC) - a briefing paper', (03.01.16). Available at: https://www.rcm.org.uk/sites/default/files/Review of Midwifery Regulation by the NMC.pdf.

RCM (2020) *RCM Calls for change to law after no midwife appointed to NMC Council*. London.

Reid, L. (2008) *Scottish midwives : twentieth-century voices*. 2nd ed. Dunfermline: Dunfermline : Black Devon Books.

Rogers, K. (2010) 'Exploring the learning experiences of final-year midwifery students', *British Journal of Midwifery*. Available: doi: 10.12968/bjom.2010.18.7.48788.

Rose, G. (2014) 'On the relation between "visual research methods" and contemporary visual culture', *The Sociological review*, 62(1), pp. 24–46.

Rose, G. (2016) *Visual methodologies: an introduction to researching with visual materials*. Los Angeles: Sage.

Said, E. (1978) *Beginnings: Intention and Method*. Baltimore: The Johns Hopkins University Press.

Sartwelle, T. P., Johnston, J. C. and Arda, B. (2017) 'A half century of electronic fetal monitoring and bioethics: silence speaks louder than words', *Maternal Health, Neonatology and Perinatology*, 3(1), p. 21. Available: doi: 10.1186/s40748-017-0060-2.

Scamell, M. (2014) '"She can't come here!" Ethics and the case of birth centre admission policy in the UK', *Journal of Medical Ethics*, 40(12), pp. 813 LP – 816. Available: doi: 10.1136/medethics-2013-101847.

Scamell, M. and Alaszewski, A. (2012) 'Fateful moments and the categorisation of risk: Midwifery practice and the ever-narrowing window of normality during childbirth', *Health, Risk and Society*, 14(2), pp. 207–221. Available: doi: 10.1080/13698575.2012.661041.

Scamell, M. and Alaszewski, A. (2016) ‘Choice, Risk, and Moral Judgement: Using Discourse Analysis to Identify the Moral Component of Midwives’ Discourses’, in Crichton, J., Candlin, C. N., and Firkins, A. S. (eds) *Communicating Risk*. London: Springer, pp. 67–82.

Scanlon, Lesley (2011) ‘‘Becoming’a professional’, in Scanlon, L (ed.) *“Becoming” a Professional*. Dordrecht: Springer, pp. 13–32.

Schiffrin, D. (1990) ‘The management of a co-operative self during argument: The role of opinions and stories’, *Conflict talk: Sociolinguistic investigations of arguments in conversations*. Cambridge University Press Cambridge, England, 241, p. 259.

Schostak, J. (1996) ‘Exploring competence in nursing and midwifery’, in Hustler, D. and McIntyre, D. (eds) *Developing Competent Teachers: Approaches to professional competence in teacher education*. David Fulton Pub.

Schostak, J. (2005) *Interviewing and representation in qualitative research*. New York: Open University Press.

Scottish Government (2017) *The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland THE*. Edinburgh.

Shopes, L. (2013) ‘Oral History’, in Denzin, N. K. and Lincoln, Y. S. (eds) *Collecting and Interpreting Qualitative Materials*. 4th edn. Sage, pp. 119–150.

Sidebotham, M., Jomeen, J. and Gamble, J. (2014) ‘Teaching evidence based practice and research through blended learning to undergraduate midwifery

students from a practice based perspective', *Nurse Education in Practice*. Elsevier, 14(2), pp. 220–224.

Skinner, J. and Maude, R. (2016) 'The tensions of uncertainty: Midwives managing risk in and of their practice', *Midwifery*. Churchill Livingstone, 38, pp. 35–41. Available: doi: 10.1016/J.MIDW.2016.03.006.

Skirton, H. *et al.* (2012) 'Preparedness of newly qualified midwives to deliver clinical care: An evaluation of pre-registration midwifery education through an analysis of key events', *Midwifery*, 28(5), pp. 660–666. Available: doi: 10.1016/j.midw.2011.08.007.

Spendlove, Z. (2018) 'Risk and boundary work in contemporary maternity care: tensions and consequences', *Health, Risk & Society*, 20(1–2), pp. 63–80. Available: doi: 10.1080/13698575.2017.1398820.

Spiby, H. *et al.* (2018) 'Preparing midwifery students for traumatic workplace events: Findings from the POPPY (programme for the prevention of posttraumatic stress disorder in midwifery) feasibility study', *Nurse Education Today*. Churchill Livingstone, 71, pp. 226–232. Available: doi: 10.1016/j.nedt.2018.09.024.

Stephenson, J. (2018) 'Professional regulation: Exclusive expert midwife attacks NMC in explosive resignation letter', *Nursing Times*.

Streeck, J., Goodwin, C. and LeBaron, C. (2011) *Embodied interaction: Language and body in the material world*. Cambridge University Press.

Sutherland, O. *et al.* (2014) 'Digital actualizations of gender and embodiment:

Microanalysis of online pregnancy discourse', *Women's Studies International Forum*. Pergamon, 47, pp. 102–114. Available: doi: 10.1016/J.WSIF.2014.05.005.

Swayne, J. G. (1846) 'Introductory Lecture on Midwifery, Delivered at the Bristol Medical School, on Thursday, Oct. 1st, 1846', *Provincial Medical and Surgical Journal (1844-1852)*, 10(42), pp. 497–501. Available at: http://www.jstor.org/stable/25499522.

Thomas, S. S. (2009) 'Early Modern Midwifery: Splitting the Profession, Connecting the History', *Journal of Social History*, 43(1), pp. 115–138. Available: doi: 10.1353/jsh.0.0215.

Tiran, D. (2017) *Baillière's midwives' dictionary.* Thirteenth, *Midwives' dictionary*. Thirteenth. Ann Arbor, Mich: ProQuest.

Tomlinson, F. (2005) 'Idealistic and Pragmatic Versions of the Discourse of Partnership', *Organization Studies*, 26(8), pp. 1169–1188. Available: doi: 10.1177/0170840605055338.

Trede, F., Macklin, R. and Bridges, D. (2012) 'Professional identity development: A review of the higher education literature', *Studies in Higher Education*, 37(3), pp. 365–384. Available: doi: 10.1080/03075079.2010.521237.

Tsoukas, H. (2005) *Complex knowledge: Studies in organizational epistemology*. Oxford University Press.

Tully, S. L. (2010) 'Student midwives' satisfaction with enquiry-based learning', *British Journal of Midwifery*. MA Healthcare London, 18(4), pp. 254–258.

Tydeman, G. and Rice, A. (2016) ‘Poor progress in labour’, *Obstetrics & Gynaecology: An Evidence-based Text for MRCOG*. CRC Press, p. 389.

Venn, C. and Terranova, T. (2009) ‘No Title’, *Introduction: Thinking after Michel Foucault*. SAGE Publications Sage UK: London, England.

Vignoles, V. L., Schwartz, S. J. and Luyckx, K. (2011) ‘Introduction: Toward an integrative view of identity’, in *Handbook of identity theory and research*. Dordrecht: Springer, pp. 1–27.

Walker, S. (2012) ‘Breech birth: An unusual normal’, *Practising Midwife*, 15(3), pp. 18–21.

Warland, J. and Glover, P. (2015) ‘Talking to pregnant women about stillbirth: Evaluating the effectiveness of an information workshop for midwives using pre and post intervention surveys’, *Nurse Education Today*. Churchill Livingstone, 35(10), pp. e21–e25. Available: doi: 10.1016/J.NEDT.2015.07.031.

Watson, C. (2006) ‘Narratives of practice and the construction of identity in teaching’, *Teachers and Teaching: Theory and Practice*, pp. 509–526. Available: doi: 10.1080/13540600600832213.

Watson, C. (2007) ‘Small stories, positioning analysis, and the doing of professional identities in learning to teach’, *Narrative Inquiry*, 2, pp. 371–389.

Watson, C. (2012) ‘Analysing narratives: the narrative construction of identity’, in. Cheltenham: Edward Elgar Publishing Ltd (Handbook of Qualitative Research in Education).

Watson, C. (2015) *Comedy and social science :towards a methodology of*

funny. Abingdon, United Kingdom; 4: Routledge.

Watson, C. and Drew, V. (2017) 'Humour and laughter in meetings: Influence, decision-making and the emergence of leadership', *DISCOURSE & COMMUNICATION*, pp. 314–329. Available at: http://ezproxy.stir.ac.uk/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edswss&AN=000401792900005&site=eds-live.

Watson, C. and Mcluckie, C. (2020) 'Analysing narratives: the narrative construction of professional identity', in Ward, R. . and Delamont, S. (eds) *Handbook of Qualitative Research in Education*. 2nd edn. Cheltenham, Gloucestershire: Edward Elgar Publishing Ltd, pp. 380–391.

Welsh, J. V and Symon, A. G. (2014) 'Unique and proforma birth plans: A qualitative exploration of midwives' experiences', *Midwifery*, 30(7), pp. 885–891. Available: doi: https://doi.org/10.1016/j.midw.2014.03.004.

Wendland, C. L. (2007) 'The Vanishing Mother', *Medical Anthropology Quarterly*, 21(2), pp. 218–233. Available: doi: 10.1525/MAQ.2007.21.2.218.218.

Wikipedia (no date) *Midwife*. Available at: https://en.wikipedia.org/wiki/Midwife#:~:text=A midwife is a health,a specialization known as midwifery.&text=They may intervene in high,%2C using non-invasive techniques. (Accessed: 20 June 2020).

Wilson, I. *et al.* (2013) 'Professional Identity in Medical Students: Pedagogical Challenges to Medical Education', *Teaching and Learning in Medicine*, 25(4), pp. 369–373. Available: doi: 10.1080/10401334.2013.827968.

Witz, A. (1992) *Professions and patriarchy*. London: Routledge.

Wodak, R. and Meyer, M. (2009) *Methods for Critical Discourse Analysis*, *Educational Philosophy and Theory*. Los Angeles: SAGE. Available: doi: 10.1111/j.1469-5812.2010.00698.x.

Wray, N. and McCall, L. (2009) '"They don't know much about us": educational reform impacts on students' learning in the clinical environment', *Advances in health sciences education*. Springer, 14(5), pp. 665–676.

Appendix 1 - Transcription conventions

<u>yes</u>	Underlining indicates emphatic stress
[laughs]::	Paralinguistic features and other information in square brackets, colons indicate start/finish
+	Pause of up to one second
++	Longer pause
=	Latched utterance
... /.....\...	Simultaneous speech
... /.....\...	
(hello)	Transcriber's best guess at an unclear utterance
?	Rising or question intonation
!	Exclamatory utterance
-	Incomplete or cut off utterance
. . . [. . .]	Section of transcript omitted