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Midwife Or Med-Wife: Examining Emotion Work with Midwifery Students in Clinical Training

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MIDWIFE OR MED-WIFE:
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TABLE OF CONTENTS

ABSTRACT

Midwives follow a holistic philosophy of care that goes beyond just medical intervention, providing support to both mother and family through the various stages of pregnancy and child birth. Yet, there is a lack of research in the US that examines how midwives invest emotion in their work, and the challenges they face when doing so. Drawing on the concept of Arlie Hochschild's (1979) emotion work as a lens for this study, I examine how midwifery students experience and manage emotion when delivering care to patients during clinical training in a large, urban hospital. Using eight qualitative, in-depth interviews with student midwives, the data suggests that students are not only managing emotion when delivering care to patients, but also when dealing with competing ideologies of care. The data reveals four intersecting themes or possible sources of emotion work for midwifery students: 1) interactions with the organization and its norms, rules and policies; 2) interactions with doctors, nurses and other staff; 3) interactions with other midwives; and 4) interactions with patients. How midwifery students are able to negotiate these relationships affects how midwives work and how they feel at work. Research from this project has contributed to knowledge on the emotional aspects of midwifery work, and may provide insight into what midwifery students are experiencing emotionally in similar midwifery programs around the US.

CHAPTER ONE

IN WHICH THE PROBLEM IS INTRODUCED

The practice of midwifery has existed for thousands of years, before modern technologies and hospitals. Although midwifery still exists, the context has definitely changed. According to Conrad (2007), "In terms of increased categories and expanded medical jurisdiction, medicalization has increased over the past century and perhaps most especially over the past three decades" (p. 121). This is especially true of childbirth in the United States. From 1996 to 2007, the cesarean rate in the US has increased by more than half, reaching an all time high of 32% (U.S. Department of Health and Human Services 2010:2). In the first years of 20th century, babies were still largely being delivered in the home, and lay midwives were the principal attendants for about half of these births (in direct competition with physicians for patient control.) Physicians began a campaign against lay midwives, labeling them as unsafe despite evidence otherwise, and by the middle of the century, births attended by lay midwives were almost non-existent (Gabay and Wolfe 1997; Dawley 2003). However, the campaign for professional expansion by physicians over the last century is only one of the many complex reasons for the disappearance of lay midwifery and an increasingly medicalized view of childbirth.

An examination by Dawley (2003) of the expansion of nurse-midwifery beginning in the 1940s and 50s demonstrates how nurse-midwives were able to seize opportunities during important historical junctures of medicalization where lay midwives

could not. Instead of fighting physicians for control, nurse-midwives joined the campaign to end lay midwifery in an effort to expand their own profession. Like physicians, nurse-midwives cited public health concerns and increasing infant mortality rates since the early century as a need for their care. Nurse-midwives could also deliver a more natural childbirth experience, called for by women reformers at the time. They also were able to work in newly built hospitals where many patients were beginning to use health insurance plans, and could help deliver the large numbers of baby boomers being delivered at the time. According to Gabay and Wolfe (1997), "Trained nurse-midwives represented something of a compromise between lay midwives, whom they increasingly replaced, and the medical profession. The regulatory environment governing midwifery care that emerged in the early part of this century ensured a measure of physician involvement and control" (p. 392). Nurse-midwifery was officially recognized in 1971 by the American College of Obstetricians and Gynecologists in a joint statement with the American College of Nurse-Midwives (Gabay and Wolfe 1997), and the profession has been slowly building its place in the childbirth industry since then.

Midwifery now exists as a profession that is largely misunderstood, both by the general public and the medical profession. A study by DeJoy (2010) of 459 undergraduate students in a public health class found that,

> Childbirth [was believed] to be inherently dangerous and unpredictable, and technology, in the hands of a highly educated technical expert, as a necessity to control risks to mothers and infants...Midwives [were] seen as caring, but less-educated, health care providers who eschew expensive and potentially life-saving technologic interventions. (P. 121)

As explained by one of my respondents in this study, Kelly, "I have to tell every single person I meet what a midwife is. My own father didn't know what a midwife was until after two years of me telling him what I was doing. He's like, I don't understand, you sound like you're a doctor" (Kelly, Midwifery Student). There are many different types of midwives, including Certified Professional Midwives (CPMs), Certified Midwives (CMs), direct-entry and lay midwives. This project focuses on CNMs, or Certified Nurse-Midwives. CNMs have a master's degree in nursing with a specialty in nurse-midwifery. Before nurse-midwives can go on to practice and become professionally licensed, they take a certification examination administered by the American Midwifery Certification Board (AMCB). Certified Nurse-Midwives usually end up working in hospitals, although some CNMs do work in private, community-based or homebirth settings.

Midwives are primary healthcare providers specializing in women's health throughout the lifespan. They deliver around 7-8% of all babies born in hospitals, where almost all babies are born under hospital care in the United States (U.S. Department of Health and Human Services 2011:13). However, midwives do not only specialize in pregnancy. Midwives offer family planning, gynecological services, and can even help prevent pregnancy. They can order tests, diagnose diseases, prescribe medication, and discharge patients. A 19-page long statement, released by the International Confederation of Midwives in 2011, outlines the basic and core competencies of a midwife, or the "knowledge, skills and behaviors required of the midwife for safe practice in any setting" (International Confederation of Midwives 2011:1). Many of these skills are medically based, including procedures such as performing episiotomies, managing caught cords,

and administering emergency resuscitation (International Confederation of Midwives). Despite midwives only delivering a small number of children in the U.S., midwifery care has been proven to be just as safe (if not safer) than doctor based care.

According to the latest international rankings, "In 2005, the US ranked 30th in the world in infant mortality, behind most European countries, Canada, Australia, New Zealand, Hong Kong, Singapore, Japan and Israel," (U.S. Department of Health and Human Services 2009:2). In most of these other countries, midwives are often the main practitioners who deliver children. For instance, in England from 2010-2011, 56.6% of deliveries were performed by midwives (NHS Maternity Statistics, 2010-2011). Midwifery care is often cheaper than doctor based care. One reason is that midwives attempt to avoid the use of any unnecessary (and expensive) medical intervention during childbirth. Unlike obstetricians who believe that birth should be managed, midwives view birth as a normal event. In 2010, the total health expenditure in the United States reached almost 2.6 trillion dollars (or 18% of the Gross Domestic Product), with $814 million spent on hospital care (National Health Statistics 2010 Highlights). Still, the United States fails to reach an infant mortality rate comparable to other wealthy and industrialized countries.

One of the highest factors for infant mortality in the United States is low-birth weight or pre-term birth (U.S. Department of Health and Human Services 2009:1). Despite the high cost of healthcare in the U.S., it is often low income women who do not have access to medical care (Kaiser Women's Health Survey 2004:1). As pointed out by Gabay and Wolfe (1997), midwifery care is not only cheaper, but also focuses on patient

education, communication, and individualization. Midwives can therefore provide benefits to women who need more knowledge and flexibility in their care. As Kelly explained:

> It's the belief that there is more to caring for someone than their physical needs. There is more to telling a woman that she needs to eat fresh fruits and vegetables if she has no place to go buy fresh fruits and vegetables. Understanding not only your client, but your client's environment, your client's stress level. Essentially putting yourself in your client's position, and if I want my client to eat more green leafy vegetables, I might have to figure out something that might not be so healthy, but it's going to fit the bill for her. (Kelly)

Midwives are also trained in psycho-social aspects of care. Midwives can be a great source of support to both women and their families. However, there are few sociological studies in the United States examining this area of work from the perspective of midwives.

The main premise for this study was inspired by Hunter (2001; 2004; 2005), who has extensively examined midwifery work in the UK. Hunter uses Hochschild's (1979; 1983) theory of emotion work in order to examine midwifery care from the perspective of midwives, from students to certified midwives, and community to hospital-based. What she discovered was that midwives often confront conflicting models of care within their profession, largely based on the practice setting. However, student midwives seemed to be somehow caught in the middle. Where hospital midwives tended to be more medically based and less patient focused, community midwives found satisfaction in bonding with their patients. Midwives who had been employed at the hospital for quite some time tended to concentrate more on institutional demands. Students, although also trained at a hospital, tended to be more patient focused and believed strongly in the midwifery model

of care, or a more holistic and natural approach, similar to that of community-based midwives. Using Hochschild's and Hunter's ideas, I decided to conduct this study. The purpose for this study are as follows: 1) to examine midwifery's students early expectations of their work and philosophy of care, before they entered clinical training; 2) to examine how and if those expectations were met (or not met) in their clinical work (especially in regards to psychosocial and holistic care); and 3) to discover how these discrepancies, if any, affected students and their work. Once these questions have been answered, I use Hochschild's (1979) theory of emotion work as an analysis tool in order to examine the data.

Literature Review

In 1979, Arlie Hochschild first developed the concept of emotion work in, "Emotion Work, Feeling Rules, and Social Structure." As Hochschild (1979) explains, "Emotion can be and often is subject to acts of management. The individual often works on inducing or inhibiting feelings so as to render them 'appropriate' to a situation," (p. 551). Hochschild (1979) calls this an interactive account of emotion. She argues that emotion is not just biological in nature but also deeply social. Humans are not just subject to uncontrollable floods of emotion. Rather, emotion can be managed in accordance with social norms. Hochschild (1979) states that, "In the interactive account, social influences permeate emotion more insistently, more effectively, and at more theoretically posited junctures" (p. 554). Emotion management is a deliberate and active process, where "reflecting on and shaping inner feelings [is] a habit distributed variously across time, age, class, and locale" (1979:57). Emotion management does not simply mean that

individuals put on a "show" of emotion. People evoke and suppress real feelings in accordance to the situation.

Social norms that relate specifically to the display of emotion are what Hochschild (1979) calls feeling rules. Feeling rules delineate how one should feel in a situation and leaves room for a little bit of play and interpretation. According to Hochschild (1979), "The individual compares and measures experience against an expectation often idealized. It is left for motivation ('what I want to feel') to mediate between feeling rule ('what I should feel') and emotion work ('what I try to feel')" (p. 565). People interpret feeling rules through what Hochschild (1979) calls framing rules, or the "rules according to which we ascribe definitions and meanings to situations" (p. 566). Rules relate specifically to social context and can often contradict each other. When humans interact with each other, they apply these rules to the social exchange. Each person knows what the other is owed and what should be received in return. Feeling rules (and the exchanges they guide) can be obeyed, stretched or broken. Individuals remind and sanction others when rules are violated, whereas compliance is often followed with a reward.

When emotion work is done for a wage, researchers often refer to it as emotional labor. As described by Hunter (2001), emotional labor happens when "workers strive to create and maintain a relationship, a mood or a feeling" (p. 437). As Hochschild (1983) explains in her book, workers utilize emotional labor "in order to sustain the outward countenance that produces the proper state of mind in others," or in the case of the flight attendants she studies, "the sense [on the part of airline passengers] of being cared for in

a convivial and safe place" (p. 7). However, the work that goes into emotional labor is not entirely up to the individual. According to Grandey (2000), "Emotions are managed in response to the display rules for the organization or job. These rules regarding the expectations for emotional expression may be stated explicitly in selection and training materials, or known by observation of coworkers" (p. 95). Put together, these concepts are what make public or paid emotional labor, different from the emotion work that many people engage in as part of their daily lives. As paid employees, midwives have an obligation to and are trained in accordance with organizational norms and rules. They are also trained exclusively in the work of midwifery. The work of Conrad (2010), Hunter (2001; 2004; 2005), and McCrea and Crute (1991) have explored how these two obligations coexist for midwives. Bone (2007) also explores a similar experience with labor and delivery nurses.

Using qualitative interviews, McCrea and Crute (1991) uncover how 16 midwives of varying grades engage in emotional labor while working in a hospital in Ireland. Agreeing that midwives meet physical needs as well as emotional, the authors state that midwives can have a positive or negative impact on a mothers' experience. The authors explore the factors that contribute to what midwives describe as good or bad therapeutic experiences. McCrea and Crute (1991) report that conflicts at work caused dilemmas in midwives' everyday interactions with clients. How midwives were able to navigate these conflicts determined the quality of the therapeutic relationship. The authors identify four intersecting areas of conflict: quality of midwives self-worth; midwives' availability for

autonomy and authority; deciding on the amount of emotional involvement with clients; and ensuring honestly and trust with clients.

Midwives described dilemmas in these areas stemming from relationships with both clients and the organization. For example, midwives had to adjust to clients who were unresponsive and unable to develop a close, personal relationship. Less responsive patients also negatively affected the midwives' feelings of self-worth, because midwives believed that creating bonds are part of their job. In McCrea and Crute's (1991) study, "Midwives described how they felt confident when they were able to 'do something' for clients" (p. 187). Midwives also had to consider organizational norms and rules. For example, autonomy and authority as a midwife is dependent on hospital hierarchy and organizational procedures such as avoiding risk. When midwives had to hand over their work to obstetricians, it could affect their relationships with clients or feelings of autonomy. Furthermore, although many midwives wanted to ensure honesty and trust with their patients, organizational norms such as how much to tell a client could cause problems. In many ways, midwives were caught between their commitment to both patients and the organization.

In a qualitative study from South Wales, Hunter (2004; 2005) examines both hospital and community-based midwives using focus groups, observations and interviews. She explores how midwives experience and manage emotion, and whether they describe these experiences as emotionally rewarding or difficult. Hunter finds that emotion work in midwifery is largely related to "the co-existence of contradictory ideologies of midwifery practice… which were linked to the context in which midwives

worked" (2004:266). Hunter explains that hospital-based midwifery is driven by the need to service a large number of patients on a daily basis in a safe and efficient manner. Hospitals often implement a universalistic and medicalized approach to care in order to reduce risk, so that patients can be successfully sent home. While meeting the needs of the institution, there was less time for hospital-based midwives to perform more personalized care that satisfied every patient's needs. The same was not true for community-based midwives.

According to Hunter (2004), "Community-based midwives were more likely to work according to a 'with woman' approach to practice. This approach was characterized by an individualized, women-centered model of care, informed by the belief in the normal physiology of childbirth" (p. 266). Although community-based midwives described their work as emotionally demanding, they also reported that it is rewarding to offer support. In comparison, many of the midwives who worked in the hospital described experiencing a mix of negative emotions such as "frustration, anxiety and anger" (Hunter 2004:266). This was due to a conflict between their personal ideals for practice and the approach that the organization required. Like community midwives, students working in hospital-based midwifery often presented themselves as strong advocates of the 'with woman' ideology, in opposition to the 'with institution' ideology held by more senior midwives who had been working at the hospital for longer. Furthermore, integrated midwives, or midwives who work in both hospital and community-based settings, also often held a 'with woman' approach to care and found it difficult to transition to work at the hospital. In response, students and integrated

midwives engaged in emotion work in order to maintain an appropriate professional performance.

An Australian study by Carolan (2010) further explores how student midwives may find their ideals challenged in hospital-based midwifery. In her qualitative study, Carolan (2010) asks student midwives to describe the qualities of a good midwife. Many of the attributes that the students reported spoke of elements of psychosocial care. For instance, a good midwife was friendly, caring and supportive. Students also strongly believed in the naturalness of childbirth. However, Carolan (2010) finds that students may be surprised once they enter clinical training.

> Compared with midwives, students in this study were more effusive in their identification of the emotional support that the midwife should provide... This situation has the potential to cause student dissatisfaction if the reality of the clinical role does not meet expectations. Students may also be unprepared for the degree of difficulty of theoretical and clinical knowledge acquisition when midwifery is viewed as a primarily social and supportive role. (P. 507)

Although her findings are telling, Carolan (2010) only reports views of midwifery students before they enter training. A research study conducted after students entered clinical training would reveal whether and how students are actually dealing with these struggles.

Although emotion work has not been explored much from the context of midwifery work in the United States, there have been studies from the views of maternity nurses who also often engage in emotion work as part of their job. According to Bone (2009), “In the United States, 99 percent of all babies are born in hospitals where medical doctors, usually obstetricians, oversee about 92 percent of the births” (p. 56). Bone states that the maternity nurses who often assist in these labors are the ones who frequently

provide emotional support to women. Her qualitative study includes six nurses who work in maternity wards in California. As Bone (2009) explains, "Both the emotion work of 'doing' interpersonal relations and how they managed their own feelings about the working conditions were explored" (p. 58). Like studies from the UK, Bone finds that nurses were caught between their commitment to their patients and the organization in which they worked.

As she explains, "Maternity nurses are often caught between conflicting demands of medical science and technologies, and the commitment to meeting immediate needs of the patients they serve, including interpersonal and emotional dynamics" (p. 58). For example, nurses felt they had to get to know the patient personally, but also medically through charts, monitors and tests. Medical intervention also effected opportunities for emotion work. Patients who received epidurals and anesthesia needed less emotional and pain support. At the same time, nurses had to keep a close eye on fetal monitors while patients were drugged. Nurses reported that emotional involvement with patients was not necessarily a job requirement. Their employers did not consider it an essential part of the nurses' work. As Bone states, "The nurses I interviewed expressed frustration and anger about intensifications of work and resultant changes in standards of patient care. With so many tasks, they explained that providing deep emotional support was an ever-lower priority" (p. 66). As a result, nurses described self-monitoring in which they decided how much or how little to get involved with a patient. However, even with its difficulties, nurses described psycho-social support as a source of personal satisfaction.

Since Arlie Hochschild (1983) applied the concept of emotion work specifically to paid labor while focusing on the work of flight attendants, researchers have continued to apply her concept in order to explore many different occupations. Hochschild (1979) explains, "The emotion management perspective can be applied to any number of areas. We know little about how feeling rules vary in content from one occupation to another" (p. 572). Research is needed in the area of midwifery because midwives often engage in emotion work or emotional labor as part of their job. Although researchers have examined similar occupations such as nursing work, or midwives in the United Kingdom, as Smith (2009) states, "It appears that emotion work is different for different occupational groups dependent on different clinical contexts and organizational set-ups" (p. xii). Therefore, work is needed specifically in the area of midwifery within the context of the current United States health care system. This research will very likely yield its own distinctive results relevant to the work of US midwives.

Research Methodology

I began this study knowing little to nothing about what midwifery actually was or what it is that midwives do. In October 2010, when my advisor asked what I wanted to do my thesis on, coming out of a medicalization class I had just enjoyed, I blurted out, "Midwives." She asked, "What about midwives?" I had no idea. I began on a literature search and stumbled upon a few articles that interested me. Those articles grew into a literature review, and eventually gave me the ideas and basis for this paper. Although I learned a lot from the literature (or at least I thought I did), most of what I learned about midwifery was through the students who participated in this project. Now that I have

collected this data, I consider myself to be an advocate of midwifery for all women, and I continue to personally research the subject.

In order to begin this project I had to pick a site. More importantly, I had to gain access. Using the internet, I found a nurse-midwifery program at a local university that I felt was large enough to provide an adequate study population. After approving the site selection with my advisor, I drafted a formal letter, briefly explaining who I was and the purpose of my study. In October 2010, I sent the letter to the head of the department at the university I chose. In November 2010, I received a response by e-mail from the department head, expressing an interest in my study. She also connected me with their department coordinator, who would immediately become my main liaison at the site. In February 2011, the department coordinator and I completed and filed paperwork required by the site IRB in order to gain permission for the study. Gaining approval was somewhat difficult, in that the site IRB required three revisions and special assurances on patient protection. Once approval was gained in May 2011, I also had to acquire an ID badge in order to access the hospital for observations. For this I was required to receive immunizations, pass a drug test, a background check, and I had to sign various amounts of paperwork, before finally being administered an official ID. Because I was doing this project as a student at Loyola University, I also had to gain approval from Loyola's IRB, which was acquired in March 2011.

The data for this project includes eight semi-structured interviews with nurse-midwifery students studying at a large, urban University with a teaching hospital on site. Interviews were conducted between August 2011 and November 2011. All of the

participants were women, ranging in age from mid-twenties to mid-thirties. (Midwives throughout this paper will be referred to as she, although there are some male midwives. Student's names were also changed in order to protect their identity.) All of the students in this study were white. Some of the students had children themselves, while others were non-mothers. Although the midwives were all studying at the same school, students had nursing jobs or clinical placements at a variety of locations, including community-based settings, other hospitals and even abroad. How these students described their work is a reflection of all of these experiences.

Students were recruited through an e-mail message and a presentation held in an upper level nurse-midwifery class at the college. The possible number of participants for this study totaled above 50 students. The sampling procedure for this project was fairly open. Students who participated in interviews were required to have at least one semester of clinical experience, although most of the participants were near the end of their degree and/or clinical requirements. I sometimes tried to use snowball sampling. I either asked students to encourage their friends and classmates to participate, or if a student mentioned a specific classmate that might be interested in the study, I asked their permission to e-mail that person directly using them as a reference. (Normal recruitment was through mass e-mailing to a list of students.) Overall, snowball sampling did not really help to encourage any extra participation. In fact, it was very difficult to garner participation for this project, and to arrange an interview time once participation was established. All of the students whom I recruited for this project held some kind of employment outside of school. Most of them held a BA in nursing and had outside nursing jobs. Two

participants had fellowships through the school in which they were employed. Students often claimed they were very busy. I frequently offered to meet them on campus between their classes in order to do the interviews.

It was also difficult to arrange participation for observations, even with students who had agreed to interviews. I only was able to attend one observation session at the hospital, despite numerous attempts. Although I had permission from the IRB, it was difficult to break through the hierarchy to get into the hospital setting. Often students claimed it was too busy and hectic to observe, that I may not want to, despite me telling them otherwise. Some participants may have been hesitant because as students, their clinical placements were under a more senior midwife, or preceptor. In order to receive permission for an observation session, I had to first get the consent of a midwifery student and then the approval of her preceptor, even though preceptor approval was not required by the IRB. If a student did volunteer, it was difficult to get the preceptor to agree. Often I was ignored, or a student would let me know that it was too busy that day anyway, after I had not received a response.

Interviews were open-ended and lasted from an hour to two hours. For the interview I brought an approved topic sheet that I used to guide the conversation (see Appendix A). I wanted midwifery students to explain their experiences of emotion management in their own words. For the most part, I felt that this strategy worked, and the conversation was free to flow where the student pleased. Longer interviews (or those upwards of two hours) began to take place with participants in the second half of interviewing for this project, or with the last four participants. My original goal was to

collect ten interviews, but as interviews were getting long, I felt I had reached saturation in the interview process. Data saturation, first defined by Glaser and Strauss (1967), means to hit a point in which the researcher feels no new information in the data is being found.

Interviews were tape-recorded with the student's permission and then were later transcribed by myself. After interviews were transcribed, I coded them using NVivo9 Software as an organization tool, meaning coding was manual and not performed by the program. The process for this project was largely inductive. As I transcribed my data, I recorded any initial ideas, thoughts, or possible codes using research memos. Once transcription was complete, I re-read and open-coded the interview. Interview material was coded into 22 different codes, along with a variety of research memos. After a number of interviews were transcribed and open-coded, I began to see and make connections, creating more specific codes, or what became the themes for this project. In this way, interviewing, transcribing, memo-ing and coding were all done concurrently. This process also helped me discover that I had achieved research saturation.

The method that I most closely used to code and write my paper was established by Weiss (1995) in *Learning from Strangers.* Weiss (1995) suggests a coding process using local and inclusive integration. Local integration involves organizing interview material into a series of different file folders, or codes, which I was easily able to do using the NVivo9 program. Next is inclusive integration, where I then organized the coded material into coherent sequences, establishing the story that I wanted to tell. To do this, I used an outline format. Outlines included interpreted sections from the data and

full quotes which I thought might be useful in the write up. I then used these outlines to write my final paper.

The goal of this project was to give voice to the midwifery students that were interviewed, matching their experiences and beliefs as much as possible. Interviews passed through a series of transcriptions, coding, recoding, and then a cleaning (removing redundant or "useless" words, etc), where they finally were used throughout the paper. Quotes that were not used ultimately were interpreted into the body of this paper, which I tried to keep as close to the original idea as possible. As explained by Lofland et al. (2006), "To grant that researchers are selecting out only certain pieces from the raw flux of the phenomenon that surround them does not say that they are creating those pieces. Filtering is not fabricating. A filtered reality is simply a filtered reality; it is not... a fiction" (p. 84). Part of the reality that I wanted to portray surrounded students' emotions. I often had to collect information on and interpret feelings through the words of students, which was sometimes difficult.

Throughout the research process, I felt a variety of emotions as well. Just as students' emotions were registered in interviews through their words, my emotions were often recorded through gasps, reactive expressions such as "oh wow," or through laughter. Listening to stories about losses often made me feel sad, where as I felt excitement and happiness when I heard about good outcomes. Emotions were not only felt during the interview process, but while I transcribed them as well. I noticed that in later interviews, I was able to connect with students more, often speaking of my own opinions or emotions. I often felt privileged that students would confide in me, that the

information they were sharing with me was truly exclusive and confidential. Lofland et al. (2006) explain,

> The dual task of raising and answering questions does call for a certain internal tension between distance and closeness in the researcher... a dispassionate frame of mind is particularly helpful when one is attempting to translate one's amassed data into a sophisticated and interesting analysis. But if one is to collect rich data, the tradition beckons one to 'get close.' So-called objectivity and distance vis-à-vis the field setting will usually result in a failure to collect much data that are worth analyzing. (P. 16)

With this in mind, an important part of my research process involved maintaining a balance between these two extremes.

In one way, my own emotions allowed me to better understand how students might be feeling as I interpreted the data. I also had to make sure to step back, not allowing my own emotional responses to be more than an interpretation tool. Furthermore, in sharing common emotions, I believe it helped students to open up to me, divulging information that would not necessarily be understood or told to an outsider. As Lofland et al. (2006) explain, the mere presence of an outside researcher can hamper the collection of good data, in that participants may feel too uncomfortable to act naturally. (This may be one reason why it was difficult to garner participation for observations, in that there was hesitation to "allow" me into the setting.) Bolton (2000), who studied the emotion work of gynecological nurses in England, had a similar emotional connection to the participants in her study. She speaks on building trust,

> The acceptance of the researcher as part of the nurses' community opened up their world to scrutiny and the days spend on the ward were an emotional merry-go-round of laughter, sorrow, anger, and even shock as nurses relayed their personal experiences of life on gynecology. (P. 583)

Bolton (2000) argues that only under that shared emotional experience did a "full understanding and accurate interpretation [of lived emotion] take place" (p. 583). During interviews, I also often adopted the "learner role" (Lofland et al. 2006). Much of what I learned about midwifery was through the students, and I believe the excitement and appreciation I showed for their profession encouraged students to share their knowledge.

CHAPTER TWO

IN WHICH THE DATA IS INTRODUCED

Within the general public, midwifery is not widely known or respected as a profession. Even if someone may actually know the word midwife, a number of misguided assumptions usually arise. As explained by Anna, a midwifery student, "I think that [midwifery] has a really positive connotation for some people and it has a really negative one for other people. Because when I tell people that I'm going to be a midwife, the vast majority of people are like, what?" (Anna, Midwifery Student). Many people do not know or understand that midwives are actually full practitioners, that when they deliver a child, they are the ones to "gown up" and "catch" the baby. In fact, many people still think that midwives mainly deliver at home, although they mostly work in hospitals in the US (and many other countries around the world). Although some of the midwifery students in this study desired to work in a homebirth setting, many of them verbally separated themselves from the stigma of homebirth by referring to the fact that midwives mainly work in hospitals, not at home like some people may think. Homebirth was sometimes regarded as an older form of midwifery, something that nurse-midwives have evolved from.

Many times midwives are also thought of as unsafe or that they lack proper training. In fact, Certified Nurse-Midwives, what the girls in this project are training to

become, are advanced practice nurses with a specialty in nurse-midwifery. To obtain this certification, they must receive a master's education at an accredited program. Students also pointed out this fact in order to defend their work; they were not lay midwives. Midwifery students often struggled with the negativity and misconceptions surrounding their profession. Anna went on to say, "I'm so excited to be a midwife, but I wish... that the profession has a little more respect. At one point actually I contemplated also going to be a women's health NP, just doing the extra clinical hours, just so I could say I'm a nurse practitioner" (Anna). However, students were often able to overcome these feelings and were proud of what they did. "I think it was more after I started doing the deliveries and stuff, I was like forget it. I don't really care what people think. This is awesome, this is what I want to do. I'm more proud of it, because now I'm actually doing it maybe. I could just be a midwife" (Anna). With all that is unknown about midwifery, students were also quick to make sure that people understood what it is midwives actually do.

Ideals and Beliefs

Unlike some other medical professionals, midwives believe in the naturalness of pregnancy; that birth is a normal, healthy event until proven otherwise. Midwives trust a woman's body to do its own work, using the least amount of medical intervention possible. Students explained that this meant knowing that each birth is unique, and that there are no set curves in which to guide them. Students were strong believers in evidence-based practice, or using research or theory based recommendations to support their care decisions. Because midwives attempt to avoid medical intervention, many students believed that their care should be primarily reserved for low risk patients,

although midwives often did find themselves caring for patients with pre-existing conditions or complications. Patients who desire a natural birth experience often seek midwives out for these services. They also go to them for their patient centered care. "I think that patients that come to see midwives kind of expect that extra support, and they probably should" (Anna). As explained by the students, midwifery care is designed to provide just that.

According to Michelle, midwifery is a, "body of knowledge that's owned by women" (Michelle, Midwifery Student). It is meant to empower women. Midwives have a, "high level of respect for their patients" (Michelle). With midwives, women are allowed to be the center of power and the controller of their situation and experience. For this reason, students were firm believers in patient education, or informing patients so that they fully understand their own care. Midwives have to be flexible. They have to make room for the patients' needs and wants within their care. In order to do this, they have to get to know their patients personally, which means having to spend an extended amount of time with clients. Midwives base their care upon who they are serving. Students reported changing how they talked to each client, what they recommended for their care (based on the patients' needs, wants, and what was actually possible), and how they connected with each patient emotionally. Midwives also sometimes support a patient's support group (their friends, family or even a doula) when it was needed. Midwifery is holistic. It is more than just medical. It means also considering people's social, economic and psychological needs as part of their care. However, midwives are very well trained and do perform a number of medical tasks.

Tasks and Duties

Midwives who work in the hospital environment, as they most often do, work in both clinic settings and in the labor and delivery unit. That was the case for students in this study. At the clinic, midwives see patients for a variety of reasons. Although midwives do see women in the clinic for their prenatal care, they also provide gynecological and primary health care, subscribe birth control, perform physical exams and test for STDs. Another part of clinical work is helping patients find services they need that are outside a midwife's scope of practice. This may mean referring patients to another health care provider such a mental health professional, or to organizations that can provide social resources like food or housing. Patients who come into the clinic may also have to be referred to a doctor if their care is considered too high risk. At the hospital in the labor and delivery unit, midwives deliver children and provide post-partum care. There is also a triage center where they treat patient emergencies (while women are pregnant) and rule women in and out of labor.

Reasons for Becoming a Midwife

Midwifery students had a variety of reasons for becoming a midwife. Students talked about wanting to make a direct impact in the world, especially regarding women's health. They brought up a number of social and health issues that they believed could be addressed by midwifery care, such as reproductive and women's rights, perceived issues in pregnancy care, and health promotion. Some students knew early on that they wanted to become a midwife, going straight into graduate school after their bachelor's degree in a related field. Other students had more serendipitous routes. Some entered the health or

nursing field first and then worked their way into midwifery. Kelly commented on nurses who eventually become midwives.

> They get to a point where they can't do anything as an L&D nurse anymore. You want to do more for your people that you're caring for, but you're limited by your scope as an RN. As a midwife you can make decisions for them. As I've gotten to a point now in L&D where I'm comfortable, I can see how, if I hadn't been in midwifery school I would be applying to midwifery school, because I am at the point now where I understand the nursing part of it. I want to do more for my patients. (Kelly)

Other students came from jobs and majors completely outside of the realm of midwifery, changing their career path in the process. Often these students came in with no previous healthcare experience. For this, the college has a direct entry program.

How students heard about or researched a career in midwifery varied as well. Students researched online, or often talked to others. Some people had friends or family in the healthcare field, sometimes specifically in nursing or midwifery. A number of students shadowed with a midwife before deciding that midwifery is what they wanted to do. Those who were nurses first were able to try out the labor and delivery unit before becoming a midwife. Other students talked of trying a variety of nursing units before they decided on labor and delivery. Many students met with advisors and faculty at the school. Students who received their nursing degree from the same school where the midwifery program was located spoke of being targeted or encouraged to move on to the midwifery program. Once students found their way into the field, many of them spoke of moments where they realized that they had made the right decision. As Samantha explained, "Within the month that I was in labor and delivery I knew I wanted to do it" (Samantha, Midwifery Student). Despite students researching their career choice beforehand, many

still spoke of being unsure about what a midwife's actual full scope of practice was before entering school.

Learning to Be a Midwife

Many students started out their class work by taking the first few semesters online. They thought this approach would be convenient, since they were able to work on their own time, but students had to be disciplined in order to finish their work. Many students described not enjoying online classes once they had enrolled. They were recounted as isolating and boring. Although students could discuss class issues on discussion boards, they preferred the energy of face-to-face interaction. As told by Jackie, "There are discussion boards where people type in and share comments and respond to one another, but I just don't think it's the same experience when you're in a room together sharing ideas" (Jackie, Midwifery Student). Many students also said they would have preferred to have a live professor instead of having to e-mail and wait for answers to their questions.

Much of what students learned was acquired during clinical placement, either while working at the clinic office or in the hospital. Students described each area as informing the other. Students preferred the hands on experience of clinical work. In Michelle's opinion,

> Everything we do is physical. I personally had nothing to apply my knowledge to until I started clinical. Because I never worked in a hospital. Learning for an entire semester about birth management, when I've never been in births, and I'm not currently attending births... in one ear and out the other. I'll cram for tests just to memorize stuff, but it's really not the same. (Michelle)

Hands-on learning was especially helpful in developing practical skills such as suturing, reading lab work, or attaching monitors. Students also had to learn how the hospital was run, whether it was familiarizing themselves with policies or procedures, where to locate supplies, or the interpersonal culture of the working environment. In clinical, students often encountered emergencies or unplanned situations where things went awry. In these instances, students described forgetting or not being able to recall their in-class training as quickly. Sometimes their mentors were able to guide them through it, or students would improvise. In retrospect, students thought of such situations as good learning experiences.

Learning from or modeling others in clinic was especially important. Students did not only learn practical skills, but also how to interact with nurses, doctors and patients. Books were not able to express the emotions students would feel in clinic, or those that would arise within their clients. Anna spoke of what they touched on in class, "I don't think we've spent that much time on the emotional thing. But I do think that comes more with experience, it's hard to teach in a classroom... I do like kind of watching the midwives and listening to them and seeing what they do. I learn really well from that" (Anna). The same went for conflicts with doctors or other co-workers such as nurses. However, through class, students were able to understand and back up practice decisions using the evidence-based research or theory they studied. Overall, midwifery students found their training to be more medically based and therefore suited to work in a hospital setting. As Molly explained, "We've very much being trained to work in a hospital setting and manage through a medical orientation. That's really the drawback for me personally.

But I guess since I will likely not be doing homebirth, I'll work in a hospital, I'm being well prepared for it" (Molly). Some students were able to find supplemental materials for alternative kinds of care, either through their own research, or informal conversations with mentors who had the same orientation towards care.

Early Expectations Surrounding Midwifery

Midwifery students had a number of expectations and beliefs about what midwifery would be like after they had entered school and were dealing with actual patients at work. Although midwifery students were prepared to work in a hospital, they were not necessarily prepared for some of the obstacles it brought to providing midwifery care. Midwives believe in keeping women with their healthcare providers throughout their entire span of care (of even their lifetime), but students often found that care in the hospital was fragmented. At most places, when patients come into labor and delivery, they get whichever midwife is on call, not necessarily the midwife that they have been working with for their prenatal care. Midwifery students also thought they would be able to spend more time with patients. Instead, they felt a pressure to be efficient, finding it not always possible. The type of patients students cared for was also a surprise. "I didn't think I'd be managing patients that are as sick as they are.. That’s my main feeling of being overwhelmed" (Catherine, Midwifery Student). Many patients weren't necessarily even looking for midwifery care. In general, midwives found the hospital environment to be much more medicalized than they would have liked. Patient care often involved the use of medical interventions.

Midwifery students began to realize that their original expectations weren't being met early on, sometimes before they entered the clinical environment, while they were still doing class work.

> I thought there would be a lot more focus on the home-births and the natural remedies and the herbs, all that kind of stuff. But going through school and clinical... I feel like I wish there was more of that. I wish I could learn more about the herbs and the different techniques. I've only seen two water births ever, and I've been a part of 250 or 300 births. (Anna)

One student said she realized she had romanticized the profession in a way. At the same time, students were also unsure of what to expect before they began their clinical work, especially for those who had never worked as a nurse or in labor and delivery before. Some students had never even seen a birth before. "The first time I attended a birth it was a 'whoa' moment. Because it was only the second birth I has ever been to in my life. I felt so odd by the experience. It was a nightshift and I delivered this woman and I left that morning just feeling high on life and so amazed" (Michelle). Being unsure of what to expect caused some students to feel overwhelmed in the beginning, which was alleviated with time and experience.

Developing Authority and Confidence as a Student

When midwifery students began clinical training, many of them felt unprepared, nervous and inexperienced as a new midwife, even if they had previously worked as nurses. Catherine said,

> When you're a new nurse, you don't know anything. You know that and just learn. But when you're a new nurse for a second time, you know that you don't know anything... It's like being a freshman twice, it just isn't fun. I don't like not knowing what to do, that I'm overwhelmed... it just takes time. That's the thing about nursing, it gets better with time. (Catherine, Midwifery Student)

Some students talked about a stigma surrounding being a student or novice, that they were low on the level of hospital hierarchy. Catherine went on to say, "There's this weird dynamics in nursing about people in training. It always sucks when you're in training because then everybody is like oh my god, she doesn't know what she's doing. But that's kind of how it is in medicine" (Catherine). Feelings of nervousness were more likely to happen around other hospital staff outside of midwifery, particularly if students had no previous hospital experience. Some students thought they were often being questioned on what they were doing, or were being watched. They felt vulnerable as students, and were worried about making mistakes. This was also true when it came to being around patients.

Students talked about not wanting patients to know that they were inexperienced, especially at a certain skill they were to perform. At the same time, students had to explain to patients that they were in training. Catherine explained, "You always tell someone you're a student. But I don't routinely tell somebody this is the first time I've ever done this... because it just creates anxiety in the patient" (Catherine). Students felt they had to reassure patients. Jackie said, "I was a little nervous that the patient realized that it was my first birth. I was sure to tell her, I've delivered babies before as a nurse. So you're not really walking into someone who is a total novice I guess" (Jackie). Sometimes preceptors had to ask students if they had done a procedure before, which created an awkward situation if asked in front of a patient. To avoid this, students tried to inform preceptors of their skill set beforehand. If this did not work, they would try to let their mentor know what was going on without the patient catching on. Students sometimes put

themselves in the patients place, recalling when they themselves had refused a student procedure at a hospital, or how they might feel if they were the ones to know that their provider had not performed a skill before. This added to their feelings of nervousness.

At the same time that students felt inexperienced as novices, they also realized they were training to become providers and would have to make decisions for patients. Students found transitioning into this role somewhat difficult or overwhelming. Anna, a student from my study, described how she felt at work, "I do get a little nervous and still feel weird being the one to gown up and put the sterile gloves on and everything... It's sort of weird because as a provider I feel like I'm stepping on somebody's toes" (Anna). In emergency situations, some students were unable to gain control of the situation and yielded their power to their preceptor or another provider. In a qualitative study of eight midwifery students by Baird (2007), she found that participants had varying definitions of autonomy and what it meant to be an autonomous practitioner, despite them all coming from the same program. The students in Baird's (2007) study believed they were qualified as midwives, but that their schooling had not prepared them for autonomous practice or the realities of the clinical environment. According to Baird (2007), potential for autonomous practice was largely dependent on the practice setting in which the students worked.

However, students also enjoyed their authority. Samantha explained, "I actually get to be like the practitioner here. I have my desk, I have my computer" (Samantha). Over time, students were able to develop confidence in a number of ways. They reassured themselves that they were highly trained, often more so than the nurses who were

assisting them. Students felt better once they gained repeated experience with procedures or certain skills. Having a high number of clinical hours or catches (delivering a baby), which students needed in order to complete their degree, also helped them to develop confidence. The same went for years of experience. Once students were confident enough, they were more able to ask questions or give their opinions or ideas. However, students felt there was a fine line between confidence and over extending oneself beyond one's abilities.

Description of Hospital Environment (General)

As Baird (2007) pointed out, where a midwife will end up working has a lot to do with how she will be able to practice. As Molly explained, "I think it really depends on the practice setting" (Molly). Students described hospitals as more or less medicalized. This was determined by a number of factors. Hospitals had different rates of intervention such as higher or lower numbers of C-Sections. One has to consider who or what is on site at the hospital, such as back-up or collaborating physicians (as opposed to being on call) or the number and level of emergency teams and technologies such as NICU or anesthesia. Some hospitals have access to alternative birthing centers or alternative birthing equipment such as birthing stools, balls, and water-birth areas. Some allow more flexibility in terms of letting women birth outside the bed or walk during labor, letting them eat, or the availability of intermittent monitoring. In this way, hospitals differed on how much freedom a midwife was able to have. Hospitals have different policies and procedures which dictate when and if a midwife has to turn over her work to a collaborating physician. Policies also determine what procedures were allowed to be

performed at the hospital in general. Procedures such as delivering a woman naturally when she is breach, or vaginal births after one has had a Cesarean (called VBACs) are considered high risk.

Midwives also described varying levels of support from hospital staff such as doctors or nurses. Heather said, "I would say both the hospital administration staff is not supportive and the hospital. The physicians that work there are not supportive either" (Heather, Midwifery Student). Sometimes there were traveling staff from other practices. Midwives were also described as more or less medicalized at different hospitals. Some hospital teams did not have one cohesive philosophy on how to deliver care. Conflicts between midwives or with doctors and other staff were described by students as making the learning and working environment difficult. Switching between hospitals allowed students to gain perspective on where they had previously been (was it more or less medicalized, for example). In that way, students were able to explore different kinds of working environments. At the same time, switching between hospitals was slightly daunting for students. Heather explained, "It can just be a little bit challenging when you're spending such a really limited amount of time, you're not going to these places everyday... so you're trying to learn all of this quickly, and then so you remember it for the next time... When you're a student is just throws you off even more" (Heather). Hospitals were also described as having varying levels of patient support.

In general, students described hospitals as lacking opportunities for patient choice. As told by Catherine, "[It's about] understanding how a woman feels when she comes into a hospital, who may feel she like she needs to have a birth plan to gain a little bit of

control in a situation where it's really stacked against her in a lot of ways" (Catherine). According to Rothman (2007), "The medical management of birth means the management of birthing women: to control or to manage a situation is to control and manage individuals" (p. 61). Hospital size made a difference. Larger hospitals meant taking on a lot more patients. This effected the time midwives were allowed to spend with them. In general there was a "pressure to be efficient" and students understood that "time is money" (Molly). More patients meant that students had to take on larger loads (and had less time for learning), and they were not able to give as much individualized care. Heather said, "I think that's probably the advantage for people who work in smaller practices, is that you really get to know your patients" (Heather). Different hospitals also had different work shifts, ranging from being on call to 12 to 24 hour shifts. On call midwives were usually called when their particular patients were going into labor, allowing for practitioner consistency. Having a longer shift meant you had more potential time to spend with a patient throughout their labor. It also meant having to work longer hours. Time off was needed to recuperate. Finally, larger hospitals meant having more hospital staff that students would have to interact with.

Different hospitals also take on different kinds of patients. Factors such as who is on site and what technologies are available (such as a NICU) help determine the risk level of patients. As told by Catherine, "You have your in-house docs right there, the residents are there, everybody's there. So in a hospital where you don't have as much back up, you're not going to take care of patients who are a little bit more riskier" (Catherine). NICU levels range from Level I to III, which is established by the American Academy of

Pediatrics. Level III NICUs are the highest, meaning they have the best resources to deliver the highest amount of care to the sickest of babies (American Academy of Pediatrics). Different hospitals also have different kinds of patient populations. There are both private and public hospitals, which take a range of patients from self-paid, insured, uninsured and those on Medicaid. Who comes to the hospital is also largely determined by the surrounding area, depending on where it is and who lives there. Larger hospitals usually see more of a diversity of patients. Lower income or immigrant neighborhoods can present certain challenges to midwives such as language and cultural barriers or difficulties with patients' perceived lack of social resources or support systems. Michelle explained, "The other thing is the type of patients that we serve. By and large they feel like a very easy population to care for. I think that's very different from a lot of the situations that the midwives at [the other hospital] care for" (Michelle). Switching hospitals also meant being able to see a diversity of patients between different hospitals.

It was clear that students understood that practice setting meant a lot in terms of how they would be able to give care. In that way, their experience in clinic helped determine the environment in which they would likely end up practicing. McCall, Wray and McKenna (2009) find that,

> Clinical placements are a crucial component for midwifery preparation. Not only do such placements provide opportunities to develop competence with clinical practice, they challenge students' preconceived ideas about midwifery practice, and assist them to develop perspectives on, and directions for, their future careers. (P. 410)

A few of the students from my study already knew that they wanted to stay away from the hospital environment as much as possible, and would practice at home instead. Molly

said, "One of the things that I think I really like about homebirth... you're just with one woman during birth at a time, you're not running crazy back and forth, you're not dealing with higher risk patients, those things that we didn't want to go to medical school for" (Molly). However, most of the students said that they would most likely end up working in a hospital.

Some students wanted to at least be in a hospital with a birth center, or where they could have more flexibility to practice midwifery as they wanted to. As Michelle described,

> I would like to be in a place where there are no TVs in the room, and there's music that plays, and there's water births and there's a calmer approach, and woman can labor for as long as they want... and more things that could support natural birth... I think part of it is it's a hospital and it's going to look like a hospital. But I would like to be able to bring in music and bring in fragrances that can be pleasing to laboring women. I would like to know more about alternative pain management things, to drugs. I'm not quite sure I'm getting that set of experiences right now. (Michelle)

At the same time, students realized that there would still be difficulties, and that practicing midwifery in a hospital would be a challenge to overcome. Private practices located within hospitals were also more flexible. Midwives at private clinics are paid through their patients and are not on the hospital payroll, so they may be more inclined to deliver patient centered care. They also have the freedom to make their own policies for care, within a certain standard.

Description of the Site Hospital (At the School)

Many students had part or all of their clinical experience at the on-site teaching hospital where they also attended school at the college. There was both a clinic office and a labor and delivery unit (with a triage center) at the hospital. The clinic holds regular

office hours and midwives at the hospital work on 12 hour shifts. Clinic work is appointment based, where as patients who come into the hospital get whoever is on call. Midwives there were employed by the hospital and had to collaborate with physicians in the unit. The hospital was described as very large, having many patients, and was often very busy. Midwives there felt pressure to be efficient. Students described a lot of people in the room when a woman was delivering, whether it was the patients' friends and family, midwives, nurses, doctors, or an emergency team. Michelle described, "And everybody bustled in, it was just chaotic, like okay everybody! Get her to the labor room! It's an emergency! This is so typical of [that hospital] too, like she's going to have a baby, that's crazy!" (Michelle). Having such a large institution also meant seeing more of a diversity of patients. Some patients who came to the hospital were not even requesting midwifery care or a natural birth experience. Patients were automatically assigned to midwives unless they are determined to be too high risk, in which case they were transferred to a doctor. Residents who worked in the unit also needed their own clinical experiences, so there may have been some inclination to transfer births to them.

The hospital often took on higher risk patients, partly because they had a Level III NICU. Midwives also reported having to take on patients who were high risk because of pre-existing issues such as diabetes, hypertension, they were overweight or had high blood pressure. Molly said, "A lot of their patients seem to be more high risk they're managing, even for midwives" (Molly). The hospital also allowed higher risk procedures to be performed such as VBACs or inductions. However, this particular site did have the lowest number of C-Sections in the city, and the state. In general, the hospital was

described as less flexible. They rarely allowed patients to labor outside of the bed and there was no alternative birthing center, or water births. Care was a lot more medicalized. A lot of patients received epidurals. Medicalized care may have been partly due to the collaborative agreement between the midwives and physicians. Midwives had to report back to the supervising physician on call in the unit. Kelly pointed out,

> The care that we give is midwifery, but the policy that we have to follow is medical. We have to do certain things we may present because our collaborating physicians tell us we have to... The physicians help create the policy... sometimes they are more conservative so, because they want that, they want their midwives to want that. But our policy is... very different. (Kelly)

Having a large midwifery team at the hospital also meant that not all midwives had the same practice philosophy and there was less cohesiveness between their giving of care.

Reports coming back from student experiences at the hospital were generally negative and they had a variety of complaints. Some had feelings of vulnerability and of being unsupported as students. Students also found it problematic to apply their schooling or personal philosophies in that particular hospital environment, especially regarding patient centered or holistic care. A study by Lange (2006) suggests that in the basic sciences, it is often preferred to have extensive schooling in a classroom before implementing what one has learned into practice. This however may create a theory-practice gap, where "theoretical knowledge may seem to the student or new practitioner to have little relevance to the actual 'applied' part of the curriculum, which deals with everyday complex and unpredictable events" (p. 71). In Lange's (2006) quantitative study of 39 newly certified midwifery students in the US, she found that practice setting was more relevant to what newly employed students experienced at work than what they had

learned in school. The students in Lange's (2006) study found that normal, holistic, and emotional care was lacking in some settings.

For the students in this study, issues at the site were compounded by another problem. Many faculty members at the college never had worked at the onsite hospital. Michelle spoke of a time she talked this over with a faculty member at the school.

> She made it clear that's a challenging place to learn... part of the challenge is that [some of the faculty at the college] have never worked at [our] hospital. So they are kind of outside of the realm of... She's like, [some of us] don't share that philosophy, and we've never been in that practice, and so their expectations are different from what we expect of you as students. (Michelle)

Some faculty at the school have little to no direct experience with what students are dealing with at the hospital. Students reported having discussed their feelings about the hospital with other students, finding out they also felt the same way about their experiences. Some of the students reported "worse" locations than that particular hospital during the interview, in that they could be even less flexible, more medicalized, or were resistant to or lacking midwives in general.

Time

Time was repeatedly cited by students as an important factor regarding their work. Students talked about needing time for them. They said it was nice to have "time to recuperate, take a breather, or decompress," either after long shifts or between patients. Many students said they needed time at work to learn, which was difficult to accomplish if they were busy completing tasks, left alone, or taking care of patients all day. Preceptors also needed time to be able to teach students. Many students talked about how charting could take up a lot of time, especially since they were still learning how to chart.

Some said they had to catch up on charting after meeting with patients, when there was extra time to do so.

Midwifery students also strongly believed in providing patients time. This could mean allowing patients time to talk, to progress during delivery, or to process information such as a loss or options for care. Patient time could be spent with a student, as a support person, or alone, depending on what the student felt the patient needed. Students needed prolonged time with patients in order to develop a bond, built rapport, and to get to know them. Although it was often very busy in the labor and delivery unit, students also reported feeling rushed through appointments at the clinic. When they were pressed for time, students reported feeling "overwhelmed, guilty, disappointed, and disheartened." However, students also said they disliked slower days, which could be boring. It seemed students wanted to meet somewhere in the middle, in between being overworked and sufficiently occupied.

Students had a variety of strategies for dealing with a lack of time, although it was said that "you can't change [not having time], it comes with the territory, you just get used to [it] or, you don't even think about it, you just deal with it." When students did not have enough time, they often had to rely on and trust a support person in their stead. This could mean a nurse or someone who came with the patient. Students said they did the "the best they could" (Molly) in situations where they were pressed for time. One student talked of how she would explain her absence to patients, "[I let] the patient know, if you need me, call, I'll be here in two seconds. But, [I also let] her know that there is a reason that [I] can't be there all the time" (Jackie). At the same time, Jackie said she hoped that

patients could not tell when she was drained or too busy. However, when asked if lack of time could affect care, one student said, "It's awful. I mean you get it done, but you definitely don't give the best care you can, because you can't. You're just doing the most minimal you have to in order to get everyone taken care of" (Samantha). Sometimes students would give patients extra time, causing the next appointment to be late. If something was missed during an appointment, students charted this information so that it could be addressed at a later date. Not having time also meant that students often made sacrifices in order to make it work, such as giving up sleep on a long shift, not taking breaks, or not eating a lunch.

Descriptions of Nurses/Nursing

Some of the students who were studying to become nurse-midwives were nurses first, before they moved onto midwifery. Others only had experiences with nurses after they entered midwifery school and received their BA from the fast track program. Students described nursing or nurses in a number of ways. Many students depicted nurses as supporters; they did not make decisions like a provider would. Nurses supported patients by providing emotional care, but also by completing simple tasks in order to make them feel comfortable. They also supported providers by following orders for care, retrieving items, and ordering labs. Ultimately, nurses were not in charge of their patients or the outcome of their care. According to students, although nurses often support patients, they do so for only for a "moment in time" (Heather). They cannot establish a history with patients through prenatal care as midwives do. Nurses also have to take care of other tasks besides supporting patients. Regular nurses do not have as advanced

schooling as a certified nurse-midwife would. Unless they are an advanced practice nurse like a midwife, most nurses only have a BA degree. They are not trained to ask questions or completely understand decisions for care. Midwives and nurses also know different types and levels of skills.

Midwifery students described some nurses as stuck in their ways and not necessarily supportive of midwifery practice. Samantha remarked, "Labor delivery nurses are very strong, bull-headed people" (Samantha). Students also described a variety of interpersonal dynamics that exist within a nursing or labor and delivery unit. Nursing has its own culture, superstitions, and informal rules. Multiple students came to recite the phrase, "Nurses eat their own, and they eat their young." When asked what that meant, Heather said, "We do a very poor job of supporting each other professionally and mentoring one other... I think some of its learned behavior, I think some of it is sort of survivalist" (Heather). One student claimed nurses were never allowed to say that it was quiet on the floor, because it would then suddenly get busy.

Students talked about the "nurse curse," or demanding patients who had rigid birth plans. Nurses believed they were cursed to have bad birth outcomes or would be sent to have C-Sections if they were on the other side of labor and delivery, as patients. Demanding patients had the same fate. When asked if it was by chance, Molly explained, "I think it's nursing's response to a patient trying to take control of their situation in a setting, usually a hospital, [where] the power differential is really stacked between them and the providers" (Molly). Along those same lines then, when nurses become patients, they have a sort of "behind the scenes" view of what goes on in a labor and delivery unit.

They also have more medical knowledge than the average patient. In that sense, they have an extra form of control, skewing the typical patient-provider relationship.

Nurses may be slightly higher in hospital hierarchy than patients, but it is not always clear if student midwives are above the nurses who will later support them when they become full providers. Some students were afraid they might mess up in front of nurses. Michelle said, "I've felt embarrassed of what nurses would think of me, as a student. They were all ready to do this delivery. Then it was like, oh this stupid student messed this up. So I felt embarrassed in that regard" (Michelle). Nurses often have more experience with working at the hospital, whereas students are often just visiting for a semester or period of time. Some nurses had more practical experience than the students, especially if the first time students worked in nursing was while they were in school.

In emergency situations, some students felt that nurses should take charge or use their skills, even though students had higher levels of training than nurses. Other students saw themselves as more advanced in that regard. In Kelly's opinion,

> I'm quicker to know something is wrong than some of my people who are on the same level of experience as me in terms of nursing... I'm more likely to catch on... [if] something is not right, because of my training [as a midwife]. Not because of how long I've been a nurse but because we're trained to make decisions. So in my head I'm even making decisions, what would I do if I was this patient's midwife? (Kelly)

Sometimes students got into conflicts with nurses over patient care or what should be done in a situation, especially when they were left alone together to provide for a patient. According to Anna, work was easier, "when you get good, not good nurses, but nurses that are easy to work with" (Anna). Being a "good nurse" meant backing up midwives

and providers, especially when the hospital was busy. Part of that was following orders and completing tasks that needed to be done.

For nurses who either previously worked as midwives or those who found a nursing job while they were still in school, it was often difficult to transition back and forth. Students referred to going from midwifes to nurses as "inhabiting different roles," "crossing a line" or "boundary" at work, "switching gears," or a "shift." Heather explained, "When you're a labor and delivery nurse you think it will be a pretty simple transition, but it's very different" (Heather). When students went from midwifery to nursing, they realized they had to take a step back in order to follow orders again. They were not able to do as much for their patients as they wanted, such as direct their care or spend extended amounts of time with them.

When students acted as nurses, they expected to be bossed around by patients. Anna described it as, "She felt entitled to things like, move my pillow. Things that as a nurse you kind of just put up with, but it started to get nagging" (Anna). Back as a midwife, students often found themselves complying with patient demands, even though they did not believe they should. Anna went on, "In nursing you're used to it I think. You're used to people thinking you're also their waitress and their IT person, that kind of thing. So maybe that's part of it. As a provider you don't expect to come into that, or encounter that as much" (Anna). One student said that she still enjoyed and missed being a nurse. Finally, students reported bringing midwifery into their nursing jobs, either by encouraging patients to birth naturally, providing extra support for patients, or by taking advantage of the flexibility allowed where they worked as a nurse.

Descriptions of Doctors

Doctors were often described in opposition to midwives or midwifery. Where midwives believe that birth is natural or normal, birth for obstetricians was described as a "retrospective diagnosis" (Kelly). Doctors believe that birth is a sickness or a disease, having to be managed and standardized in order to maintain control. They are trained to look for abnormalities or risks. Students described some doctors as stuck in their ways, often basing their decisions on experience rather than evidence or theory. Doctors were generally described as less flexible than midwives, especially when it came to patient care. Students said that doctors do not care for patients' emotions, wants or needs. The patient is more of a vessel for safe pregnancy rather than a person. Rothman (2007) explains, "The Cartesian model of the body as a machine operates to make the physician a technician or mechanic... Problems in the body are technical problems requiring technical solutions" (p. 7). Doctors do not trust the body as much as they trust a monitor or test. Kelly said, "Physicians read their patients on monitors" (Kelly). She and other students expressed that doctors are typically not there to console their patients, and tend not to deliver individualized care. They also tend to talk to every patient in the same way. Under doctor based care, patients have less authority, explanations for care, and opportunities for choice.

Students often described doctors being on their own time rather than on patients' time. Students had experiences where they had to rush a delivery, which meant having to induce a woman's labor with medical interventions such as medication, C-Sections, and episiotomies. If a woman was not progressing fast enough, it could be considered a

medical risk by doctors. According to Rothman (2007), "Managing labor by the clock with interventions as necessary to speed it up, is part of the medical ethos" (p. 61). Students described situations where doctors almost missed or did miss a delivery. Doctors did not push with their patients, a nurse or midwife mostly likely did instead. Molly explained, "You wouldn't see the doctor until you were delivering" (Molly). Some doctors questioned if patients were actually ready or had a resistance to come when called, especially since some collaborating physicians work off site.

When doctors were houses off site, it was often the case that the hospital did not do VBACs. Doctors needed to be in-house for such types of procedures, and therefore they often did not want to do them. In the past 30 years or so, VBACs were considered medically high-risk, and C-Sections were recommended until the policy was reexamined in 2010 (NIH, "Vaginal Birth After Cesarean: New Insights"). Refusing to do VBACs is now considered part of the problem in the rising C-Section rate in the US (International Cesarean Awareness Network). Doctor based care was also described as more episodic. Students said that, not only did they not labor sit with patients, but when they checked-in, they tended to be rushed as well. "I felt that he came, did what he needed to do and left... Obstetricians just kind of want to (snaps), get things done and get out of the room" (Jackie). Since doctors and midwives generally disagreed on their philosophy of care, it of course led to a variety of conflicts.

Students described many doctors as being resistant to or unsupportive of midwifery care. Kelly gives her opinion,

> I think physicians started off not liking us because we were taking births from them, and because they felt like midwife was such as dirty name, because half of

> them were trained in Hillbilly Tennessee. The stigma with midwife is still associated with it. Like we're not adequately prepared, even though we might be far more prepared than their residents, who they trust. (Kelly)

Here, Kelly pointed out the historical background that is significant to the long-standing conflict between doctors and midwives. She also described how doctors may believe that midwives are not adequately prepared providers. Midwives also described issues with residents, who were training to become doctors, but were also in the learning stage like midwifery students.

Sometimes a resident was the physician in charge of the unit at a hospital. Samantha described her experience, "It's definitely a power struggle sometimes, because these new residents come in and they don't know anything. It's very intimidating for them to think that I leave there and will do what they do somewhere else" (Samantha). There were some doctors who were described by students as supportive of midwifery practice, or less medicalized in general. Supportive doctors either chose to or were not bothered to work with midwives. Students recounted them as easier to work with and generally liked. They treated midwives who practiced with them as equal partners, and were more patient centered as well. Supportive or not, students described appreciating having a back up physician in an extreme emergency, when women needed additional assistance to safely deliver a child.

Many of the students recounted conflicts with doctors (either with them or their preceptors) where they could not agree on a decision for care. Situations such as these could turn into an argument or were heated, and were reported as stressful for students. A midwife may have to or chose to compromise with the doctor's policy over her own. One

reason is that she may not feel she is in the position of power to address the situation, especially as a student. Students realized this had an effect on the care they could give. Molly explained, "I think true midwifery care is really difficult and challenging.. [one of the reasons is] because of the collaborating physicians and their management philosophy" (Molly). However, sometimes midwives chose to and were able to stand up for their beliefs.

Patients are allowed to refuse treatment, so midwives used that to their advantage. One student described a situation where she did not call the collaborating physician back after explaining that the patient wanted more time, and he wanted to rush the pregnancy along. Her preceptor agreed with her in that situation. At the time, the student had been labor sitting with the patient. Kelly described what happened, "But he's not in the *room*, so he has no proof on the monitor, so he just thinks that were not doing what were supposed to be doing. Then literally within half an hour she was pushing" (Kelly). In this case, Kelly trusted the patient's body to tell her what was happening over the monitor. If conflicts occurred in front of patients, students described being worried about how the patients would feel or react. They were often caught in the middle of having to support the collaborating physician, the patient, and their practice at the same time. Kelly said, "[We let her be angry, but] we flip it as, even though he was a total ass, we're still lucky to have good collaborating physicians" (Kelly). Students often felt the needed to follow up with a patient after a conflict.

Descriptions of Preceptors

Preceptors are certified midwifes that a student would work under, either at the clinic or the hospital. Although every preceptor is a midwife, students described them as each having her own way of doings. Heather explained, "Some of them practice alike and others practice vary differently from each other... I think most of that is within a standard of what's acceptable" (Heather). Differences may refer to variations on how they perform practical skills. Mostly students spoke of differences in terms of philosophy of care. Where students described some preceptors as providing "true" midwifery care, other preceptors were described as much more medicalized in their practice. Called "med-wives or junior OBs," these types of midwives tended to be "more like physicians" (Jackie). Med-wives were not really present for the patient. They tended not to labor sit with their patients, and would arrive when the baby was to be delivered. In Jackie's experience, "They just weren't there, they weren't being labor support.... They sometimes wouldn't even push with their patients" (Jackie). Med-wives were also not as flexible in terms of care, such as making patients birth in bed. These midwives would often utilize medical interventions with their patients, such as medication to induce labor. Students were often more critical of med-wives, and many preferred working with those had a more holistic type of care.

Students gave a variety of reasons for why some midwives fell on the more medicalized side of things. Sometimes they were pressured by collaborating physicians. Anna thought, "They just kind of fall into how all the docs do things" (Anna). If hospital policy and procedure was prohibitive to midwifery care, that could also cause a problem.

Students described some of these preceptors as having been at the hospital for a long time, or were close to retirement. Students thought they might have been burnt-out, drained, or having gotten used to the hospital environment. They may also be used to an older way of doing things, rather than practicing by evidence-based research. Students described some midwives as jaded by the patient population. Anna explained,

> I think it would be good maybe not to stay at the same place your entire career, just to get different patient populations. Some people are jaded with all the teen pregnancies, because that is all they've ever worked with. They never worked in private practices with the married people that have insurance and that kind of thing. (Anna)

Students also described older midwives or midwives in general who were said to still enjoy their work and practiced in their own way. Being at a hospital for a long time might mean having more experience in collaborating with physicians.

Students described midwifery teams within a hospital as more or less cohesive in terms of their philosophy of care. Catherine described her experience, "They all work in the same practice and they're all 100% different from each other. They couldn't be any more different, all of them" (Catherine). These groups of midwives were generally unsupportive of each other, causing inter-midwifery conflicts regarding care. Kelly said, "Even midwives have disagreements within themselves and I've *seen* this" (Kelly). Disagreements could be face to face or talked about behind someone's back, while they were not around. Molly had the opposite experience, "Those midwives were very cohesive in their practice philosophy, they all practiced the same way" (Molly). Cohesive groups of midwives were able to all agree to work as a team under a holistic philosophy of care, often despite setbacks such as the hospital environment or difficult collaborating

physicians. Private practices of midwives were better able to choose who they would allow to work at the setting. Students gave other reasons for why some units were less cohesive. Some thought that there were too many midwives in one setting. Molly explained, "There are so many midwives in that setting that I think it would be difficult to have a more cohesive manager philosophy" (Molly). At the same time, some students thought that having enough midwives was important so that they were not overpowered by collaborating physicians. Too many midwives were hard to handle, but there had to be enough to establish a team.

Students described certain preceptors as better mentors than others. Students were able to communicate well with some preceptors, feeling comfortable enough to come to them with questions or problems. Good mentors had better teaching skills or seemed to enjoy teaching more. Kelly said, "Some midwives really like teaching and some don't, and we can feel that as students. Some really take the time to teach us, and some hardly can be bothered" (Kelly). At the same time, students understood that preceptors had to deal with the busy hospital environment. Students enjoyed positive feedback or constructive criticism, and did not like when they felt as if they were being yelled at or that criticism was harsh, negative or overly critical. Michelle explained, "She has a very tough love approach that I don't find positive for learning" (Michelle). In some situations, students were criticized in front of other staff, causing them embarrassment. Students liked feeling supported, respected, and encouraged by their midwife as a collaborative partner. Anna speaks of her experience, "I remember I kind of looked at her, and she gowned up and put gloves on and everything and came and stood right next to me and

was like, if you need help, I'll help you" (Anna). When students made mistakes, good mentors did not blame them and were more forgiving. Michelle went on, "I think they forget that students are learning" (Michelle). Students did not like mentors whose expectations were too high, or when they felt pressured.

At the same time, students talked about enjoying being able to have hands-on experience, when their preceptor stepped back and let them have control of the situation. Students wanted to have room to be able to learn. Molly commented, "She doesn't give a lot of space for students to do things, she kind of jumps in and does it herself" (Molly). Students wanted to be challenged, but only to a certain extent. Michelle also explained, "My favorite midwives are the ones who push me to go find the answer and then come back and talk to them, not just tell me what it is" (Michelle). Good mentors pushed students, but not beyond their abilities or skill set. They knew where students needed extra help. Although they gave students room to work, they did not abandon them or leave them completely alone. Michelle spoke of another experience with a preceptor, "Her style is very hands-off. She is kind of like okay, what are you going to do, and it's a little bit different. It's less collaborative than I think some of the other preceptor's styles, which makes me a little nervous" (Michelle). Finally, students enjoyed mentors who were able to go beyond practical or medical skills, teaching them more about holistic or patient centered types of care.

Students said that it was more difficult to learn emotional or patient centered care in the classroom, and was better learned by modeling preceptors. Anna remarked, "Nobody really tells you what to say, I learn better from seeing the midwives and how

they interact" (Anna). However, not all midwives were able to provide these skills. Molly explained, "I think some midwives that I've seen are better at giving patient centered care... having patients truly involved in their care... I think it's totally the luck of the draw though as to which preceptor you're with in that situation and their philosophy" (Molly). Knowing that the practice setting made holistic care more difficult at times, students used more holistic types of midwives as a resource, both in learning how to deliver "true" midwifery care, and by examining how it could be done in practice situations where it may be more difficult.

Molly went on, "They were having some issues with their collaborating docs at the time, and so seeing how that relationship would be managed" (Molly). Students who wished to practice under a more holistic philosophy preferred working with these kinds of preceptors. They used them as a resource, often having informal conversations, sometimes in which the midwife could recommend alternative readings or materials for the students. A study by Licqurish and Seibold (2008), examining the preceptor's role in midwifery student learning, reported similar findings to the ones being reported here. They say,

> The students in this study identified that they prefer to work with a caring midwife preceptor, who enjoys teaching, answers questions fairly and is philosophically similar. Students also craved opportunities for responsibility for care under supportive supervision and discussion to develop their competency. Hands-on learning was emphasized as the most beneficial experience. (P. 488)

For the students in this study, being able to work with such preceptors was sometimes difficult, as preceptor assignment at the hospital was based on whoever was on call, and

not all midwives practiced with that same philosophy. (However, in the clinic setting, students were often able to work with preceptors for an entire semester.)

Students often attributed midwives' differences to their personality, character, or gender. As Heather explained, "We're primarily female, so we put a lot of females in a room and we tend to get a little catty with one another, so that's part of it" (Heather). Kelly also spoke of students' personality differences, "You might get along with one midwife better than you would another... because [your] personality and [your] beliefs match that midwife. Not everybody who is a midwife believes what I believe" (Kelly). Students seemed to recognize that personality however, could not be the only answer, as they also cited that the setting, collaborating physicians, and one's practice philosophy has a lot to do with it. For example, Kelly said, "[It's] time and personality" (Kelly). Students also recognized that midwives were trained in different places with different philosophies of care. Kelly went on, "Midwives who have been trained to think that birth is natural act more like midwives" (Kelly). Traveling midwives may also come from other practices to work at the hospital. Jackie claimed that, "They definitely bring their practices with them" (Jackie). Students also said that some midwives, having all different sorts of personalities, were still able to practice cohesively in the unit. Although students mentioned personality, it tended to be followed by practical reasons regarding why midwives had difficulties being able to teach, give holistic care, or have a cohesive practice philosophy.

Having to switch preceptors was described by the students as both positive and negative. Certain preceptors were described as better for some students than others.

Observing different preceptor styles was characterized by students as healthy and good for learning. Samantha said,

> I think that as frustrating as it is to have everybody have a different way, I think it's awesome to be exposed to so many different ways. Because as I become my own practitioner, I am being exposed to all those different ways and I can figure out what I want my way to be. Why I want that way... I don't think it's black and white. I think it's a melding of everybody's different ways and finding your own way to practice. (Samantha)

Students also talked of seeing things they definitely would not like to do, or things they especially liked. Kelly mentioned, "I am going to pick and choose what worked for me and what didn't work for me" (Kelly). Some students were surprised by and unprepared for the differences that preceptors and midwives had. It was described as a challenge to meet the new expectations of each midwife, especially after spending an extended amount of time with a certain preceptor. Jackie recalled, "As a student you're inexperienced... all of a sudden you're thrown off your feet a little bit" (Jackie). It could be uncomfortable or hard at first to get to know a new preceptor, and for her to get to know the student. Heather remarked, "I actually think that would be a benefit for me personally, just one person that I know and they also know me. So they know where my strengths are, where my opportunities are, so we can work together to get the best experience" (Heather). If a preceptor questioned a student on what they were doing, it may be uncomfortable if said in front of a patient, making the student look inexperienced. Students may feel inadequate when questioned as well.

With all the different ways that preceptors deliver care, how is it that students are able to deal? Anna said, "Some people are like I don't know who would tell you to do that, or I wonder why they would do it that way" (Anna). Students reported that other

midwives understood that everyone had a different way, sometimes acknowledging their differences ahead of time. Students preferred this approach. Students also had to be proactive in acknowledging preceptor differences. Students talked about having to "shift their framework," or being "flexible" or "adaptive." Samantha clarified, "I've made it a point of it to walk into each delivery and say okay, how do you do this, how do you do that. Because there's always different ways. Each person is different. I mean I've had one delivery where I hadn't learned yet to ask. So I mean that you just learn" (Samantha). Some students stepped back and observed first, until they got to know the preceptors style. Many of them talked to their preceptors before the day began or at the beginning of the semester, letting them know their own skill set while also asking about the preceptor's expectations. This helped avoid awkward situations in front of patients. Students reported certain preceptors being more receptive to students' requests for learning, where others found it more frustrating. Finally, switching preceptors was much easier for students in practices where there was a more cohesive practice philosophy.

Patient Care

Students described patients in a number of ways, and they attributed these differences to variations in patient care. Midwives talked of patients of all different ages, from younger patients or teen mothers, middle aged mothers, and even the "third generation grandma" (Samantha) who did not know what nurse-midwifery is. Different patients had different levels of support, whether it was no one, family and friends, or even a doula. Patients came from a variety of socio-economic backgrounds. Students referred to patients as lower, middle, and upper class. Some patients were employed, where others

were not. They might not have good social resources or even a place to live. Students also talked about patients' race, ethnicity, or immigrant status. They saw white patients as middle class, educated and insured, and saw black patients as lacking resources and having difficult living situations. According to Michelle,

> I think there are clinics, particularly in very low-income black communities... I think the patients there present certain challenges that are stressful for midwives. For instance, no access to good food in the communities, really shitty schools, tons of violence in the neighborhood... gang violence... police brutality. There are just so many different things that I think cause a lot of stress for care providers. (Michelle)

One student used cultural stereotypes in order to deliver individualized care, "When I work with Hispanic women, they're very stoic. So a little bit of love and attention and building up of energy is always good for them" (Kelly). Students also described racial or cultural differences as being a barrier for some patients in connecting with a midwife. One student said it was not a problem for her, but it seemed to be a problem on the other end.

Students commented on patients' education levels. They referred to schooling in general, or being educated on pregnancy, birth options, or midwifery care. Some patients were not specifically looking for midwifery care or a natural birth. They may want interventions like epidurals. Molly explained, "I know a lot of women come in wanting that, to be induced earlier, thing like that" (Molly). Students tended to prefer having natural birth experiences with patients, especially since they believed that birth should be normal and were learning to deliver that type of care.

> I really had a lot of respect for her. I loved that she was committed to not getting an epidural. I mean it's every woman's choice. But I think there's something really cool about women that are committed to doing it naturally, that she had breastfed her first baby, that she was breastfeeding this baby. There's just something that

> show's me she's in a particular place with her body and her baby that I think we, I can learn from. (Michelle)

Some patients did not have a choice, because they had a high risk birth. In these cases care might have to be transferred to a doctor. Some women might not want to be pregnant and/or terminate their children. Others have multiple unplanned births. Finally, both deliveries and patients were described by students as either easy or difficult. Deliveries were easy when the woman was in control of her body and there were little to no complications. Students described difficult patients as "demanding", "controlling" or "grumpy." Some patients did not follow directions or their practitioner's recommendations for care.

Individualized care was held as a high priority in midwifery philosophy. Catherine said, "My general philosophy is that care should be absolutely, 100% individualized. I also think its [the patient's] choice. So this is where it goes down to people's different philosophies... I think it should always be an open conversation with a woman that you're with" (Catherine). Spending extended time with patients helped midwives to deliver care because they got to know patients' personalities and preferences. "Some patients want you to be in their face and yell, like a big cheerleader. Other patients get very scared by that and very standoffish and they shut down. So other patients you need to be very quiet and soothing and calming" (Samantha). Individualized care might mean changing how one talks to clients based on who they are. Kelly described, "If I'm talking to someone who's got a doctorate, I'm not going to talk to them the same way I am a 17 year old" (Kelly). At the same time, Kelly explained that providers do not always need language; actions can speak louder than words. Sometimes being a presence in the

room was enough. Students also described giving individualized emotion to clients, "I think every person gets individual care from me... my emotion changes based on what the patient needs" (Kelly). Midwives used what they knew about the patient previously when giving individualized care, and they also took patient histories into account when deciding if they needed certain tests, such as when looking for STDs. Midwives might have to compromise with what the patient is able to do, such as if they can financially afford recommendations (such as buying good food) or if their insurance will cover their care.

When students met patients, they described trying to assess their needs right away, "You kind of just walk in the room and be like okay, get a feel for what the patient needs from you" (Samantha). Some students directly asked patients, where others described reading non-verbal cues or things that go unsaid. For example, if a patient is resistant to a midwife, students may pull back and give the patient space. Students reported trying a variety of ways of delivering care before finding what works for a patient. They had to be flexible and adaptive to patients' wants and needs. Students sometimes referred to using instinct, intuition or gut feelings in order to deliver patient care. One student described it as a "gift" she had. At the same time, students described assessing and caring for the patient in a very deliberate way,

> It's so instinctual. I don't know that I could put a lot of words to it but... I try to be as warm as possible and try to create a safe space with the patient by asking her how she is, and if there's any concerns going on, anything new from last time in her life. I make a particular effort to ask about her job situation, her living situation, her significant relationships, how she's handling stress. To me, how a patient will respond to those questions helps me know more about her and then what it is that I can do in the relationship to be supportive. (Michelle)

While students spoke of instincts or intuition, they also referred to a number of different skills and tricks they used in order to get to know the patient and what she wants.

Students described a variety of ways in which to bond with and support their patients. According to evidence-based research, students believed that good patient support would lead to better patient satisfaction and outcomes. Students were able to bond with some patients more than others. Sometimes, students reported clicking with a patient right off that bat, that they had some kind of connection. Mostly students had to get to know their patients personally, and doing so took time in order to build rapport. Heather explained, "I think you tend to establish a bond with people you have either previously seen maybe in the office or that you have a little more time, you need a little bit of time to do that" (Heather). Spending time with patients could mean over their entire pregnancy, during their entire labor, or in some cases, even over an entire lifetime. Sometimes these relationships turned into long lasting friendships that extended outside of work. However, some midwives reported being able to connect with patients even if they never saw them before or again, if only for a short period.

Midwives got to know family and friends of patients, sometimes caring for more than one member of a family. Students listened to patients' issues and problems, and they knew what was going on in their patients' lives. One student reported that she used jokes to bond with patients and to develop trust.

> Laughing is good for everybody right. Everybody feels good when they laugh. So if we can kind of laugh about things, it helps people feel more comfortable. People are going to tell you very personal things, so you want people to feel comfortable so you can actually help... you just want people to have a good time. Everybody hates seeing their provider. It sucks to get a Pap, it sucks to get blood

> drawn. So if you can in any way make it a little bit easier... I hope people have a good time. (Catherine)

Bolton (2000) explains, "Frequently nurses offer humour as a means of ‘getting through'... Often nurses supplement their emotional labour with humour as a way of easing tension [or] embarrassment" (p. 585). Other students let patients know a little bit about themselves, but also said they tried not to focus on themselves too much. Finally, students reported that bonding might have to do with a patients' need for you, or if the patient was open to the connection. Midwives sometimes had to step back, letting the patient's support group take the lead. At times students supported the support groups, rather than the patient herself.

Bonding was a positive experience for midwives. Students described craving a good patient connection when they had not had one in a while, "I'll come into work and be like, man, I haven't had a patient that I've really connected with in a week. It's kind of selfish of me to say that. To be like I really need that. It's not that they get better care, it just reminds me of why I like doing what I do" (Samantha). Connecting with patients was described as emotionally gratifying. Midwives also used their own emotions or feelings in order to connect with clients, often imagining how a woman might feel, or recalling their own personal experiences. Having time to get to know a patient was also important for the midwife,

> I think that those patients who I see in clinic, because you see them more frequently than you do in the hospital, there are those who you wish you will be able to then deliver, and be with them during their labor. I think that's for me right now where most of the stronger connection is. Because if I just pick up a day, or if I'm just called in for a birth at the other practice that I'm with, you often don't get the amount of time I feel to spend with somebody to develop that kind of connection. (Molly)

Midwives have a strong belief in practitioner consistency, that it is important to keep women with their providers. Students enjoyed and bonded more with patients when they were able to make a difference in the patient's life, such as supporting them through a hard delivery, being able to comfort them, and contributing to their health. When patients showed appreciation for their care, it was even better.

Trusting the client was both important in bonding with the patient and supporting patient choice. Developing a bond with a patient was much more difficult without trust. Samantha spoke on how trust is important to the client, "Patients want to know they're safe... they want to trust you. They want to know that their baby, the most important thing in their lives, is in the best hands possible" (Samantha). Students were able to build trust with their clients by letting them make their own decisions, such as how they wanted their birth to go and whether they wanted certain interventions. This involved educating the client by being open and communicative so that she was able to do so.

When midwives knew what a patient wanted, they could support them when they lost their resolve. Midwives often reassured patients when they thought they could not go on, and showed excitement for their progress during labor, "I got really stern and I was like, you are a strong woman, you can push this baby out... you can do this" (Kelly). Sometimes midwives had to advocate a patient's needs to a doctor. Students often had to learn to trust a woman's judgment. However, students also talked about giving patients enough information so that they would make the "right" decision, as opposed to her personal preference. Developing trust also meant showing that you care about the mom's and baby's safety. "You're teaching moms on how to hold their babies, how to breastfeed

their babies. They grow to trust you... You learn to really care about the baby, you look out for the baby" (Catherine). Teaching mothers how to care for their babies brought students joy and feelings of accomplishment.

Students also spoke of trusting a patient's body to deliver naturally, or to give signs or cues about what is happening during the labor, rather than relying on a monitor. Kelly described her approach,

> I don't trust monitors because monitors tell me one thing, but I'm with the patient and it's telling me another. My hand skills are probably way better than a resident's because I always put my hands on the tummy. I always feel a contraction. I always watch. I always listen. There is more to a patient than a monitor. (Kelly)

However, this was not always the case. She went on to described a different instance.

> She called the floor saying she didn't feel the baby move. And a lot of times we kind of roll our eyes and are like I'm sure the baby is moving. But there are those occasions, and this happened to be one occasion where the baby had died. But the thing was, she was in triage a couple nights before saying something was wrong. She wasn't feeling the baby move. But the baby looked really good on the monitor so we sent her home. (Kelly)

A study by Davis-Floyd and Davis (1996) examines the use of intuition by homebirth midwives, which is less valued in a more medicalized society. Midwives in the study felt they had inner feelings about birth which were both bodily and spiritual, which were connected to the deep and emotional bonds they were able to develop with a mother.

Yet the researchers go on to say, "That midwives nevertheless carry with them and freely utilize technologies demonstrates not only that they also value ratiocination, but that they are becoming experts at balancing the protocols and demands of technology obtained information with their intuitive acceptance of women's uniqueness during birth" (p. 260). It is clear that in the case with Kelly, students and midwives struggle to find that

balance with their own patients. However, it is not always their choice. When midwives felt pressured for time, they had to trust a monitor or a nurse to back them up instead of sitting with the patient. Kelly's story is only one of many examples of the importance of technology over experience.

Students also reported a variety of negative experiences with patients. When a baby or mom died or had a bad outcome, it was difficult for both the midwife and the patient. Anna explained about the patient side,

> I've been in emergencies, which can be really traumatizing for patients. But I would say the hardest part I think for sure is the losses. Or when they happen at like 41 weeks and it's a loss. The patients don't know, they're always asking why. A lot of times you don't know, which I think is hard, you don't have anything to tell them. There's just no comforting them really. (Anna)

Midwives often found it difficult to explain to patients why the medical system had failed them. Midwives often supported women in these situations, either by spending time with them, or by giving them space to process or grieve. They would often talk to patients, or would let them talk and ask questions. Individualized care was important in these instances, and midwives were careful to be sensitive to the patient's needs, such as closing her door or making sure she ate. Students believed that comforting patients during these times was part of their work, and could find satisfaction in helping the patient. "Getting the mom through a really terrible time is still part of who I am. If I can make it less painful for her but still give her some joy like, holding her baby or being kind of, doing something extra... it's still something good you know" (Kelly). Switching between a patient who had a loss and one who did not could cause a whole other problem for a midwife.

Because midwives had to take care of a variety of patients, midwives were often switching between two patient extremes. Molly spoke of a time she had a loss and a birthing mother,

> There were times when I would walk out of the room with a woman who had lost her baby and was in tears or almost in tears and then I would have to kind of get it together emotionally and go into the other room and assess a newborn... I think it was only really after that I realized how emotionally taxing that was, how I needed to compartmentalize those emotional responses to each of those situations. Which is I guess a lot of what we have to do in nursing. (Molly)

Switching between patients could be difficult for students, "I think it's emotionally taxing in some ways because you are kind of switching gears and changing gears between each room and each laboring women" (Molly). Students also had to switch between more medicalized and natural birthing patients. A good example of this is patients with and without epidurals.

According to students, epidural patients need less pain support; however they have to be medically monitored and watched for complications. Sometimes women were surprised they had any pain at all with an epidural, so they had to be supported in that regard. Midwives had to make sure epidural patients were moving around in the bed, but not too much. They sometimes needed more coaching during labor, because they could not feel the pressure of the baby. Non-epidural or natural patients are much different. Students in those cases often had to labor sit more often, especially because the baby could come quickly. Non-epidural patients also needed more pain support, since they did not have medication. Alternative methods of pain management were reported to include messaging patients, reassuring them, or helping them breathe.

There were also times when a midwife could not connect with, help, or bond with a patient. Often this had to do with the setting. Sometimes students just did not have enough time for a patient, had never met them before, or came in the middle of a labor. Other times the patient did not have time for the student and wanted to rush through their appointment. There were times patients were just closed off to the relationship, especially when there was a trauma or bad outcome. Molly explained, "She was withdrawing from it. She didn't want to be there obviously. She didn't want to be in that circumstance" (Molly). In two instances, students referred to cultural or racial differences as a barrier. One student pointed to the fact that midwives were not respected in some cultures. Also, if a client does not know exactly what a midwife is, she might not expect or know how to establish a bond. Students often referred to difficult patients or those who they could not get along with. In instances where midwives felt that patients were reckless in their pregnancy or health (for example, there was a patient who did drugs while pregnant), students described it as hard to not be judgmental.

Difficult patients were recalled as "grumpy, demanding, controlling, and disrespectful." Although midwives believe in patient centered care, students did not enjoy being ordered around by patients. Samantha described her experience, "When you come into a room and open up this relationship, treating me like this is a hotel and I'm your servant, this isn't going to be a good night. When I get treated like that, it's hard" (Samantha). Although they enjoyed feeling appreciated by a patient, students said they just dealt with or tried to manage an experience when it was not working with a client. They tried to be patient. Sometimes, students were able to break through to patients,

either over time, or with encouragement and a good attitude. Others tried not to take it personally,

> You don't have expectations. You don't know what their coping mechanisms are. They're not there to make me happy. Obviously it's very nice when you have a family who trusts you and you build a good relationship with, and that's fantastic. But, you're not going to compare. Then you have a family who doesn't trust you and it's a little more difficult. That's just the nature of medicine and that's just the way it works. You didn't pick this person, and they didn't pick you. So you just try to do the best you can. (Catherine)

Sometimes students just backed off the patient completely, allowing her to have space.

When asked if not being able to bond with a patient could affect their care, the answer was often unclear.

> I don't think the care is different, what is different is the relationship that you can establish with the patient. But you're still going to do everything that you need to do for that patient. But I suppose, I mean, care can be different because, if people put up barriers and won't give you all the information that you need to help them, in certain situations I suppose that could impact it. I haven't encountered it probably quiet enough to really know. It's definitely bothersome. I suppose that if that situation repeated I'd really have to get some additional coaching and mentoring on how do I handle this if I felt like it was affecting the care of the patient that much. (Heather)

One student said that when she was able to bond with patients, she was more encouraged to go the extra mile to give the patient a unique experience. Students described good patient connections as more fun and engaging. Bonding or getting to know the patient better also meant that a student was able to give more individualized type care. Although midwives wanted to give safe, patient centered care to all of their patients, it was clear that some students were better able to do this when the patient was receptive.

Although developing trust was a priority, there were times when trust between a midwife and patient was broken. Students wanted to advocate for patient choice, but

sometimes care did not go according to plan. Jackie explained how it could be frustrating for both the patient and midwife, "You've labored and labored and labored with someone, and they end up with a C-Section. That's so discouraging. For the patient of course, but it's discouraging for you too. That's not what you had hoped for them" (Jackie). Students tried to prepare their patients for complications by explaining what could happen before a labor began or during their clinical visits. It was difficult for them to both support patient choices and at the same time explain that birth was unpredictable.

When a deviation from the plan occurred, it could break the trust that a student and patient had established. Jackie described such an experience.

> I felt frustrated because I felt like I really understood this patient. I had told her at previous visits, I totally understand your not wanting to be induced, we love natural labor. I very much felt like I was on the same page with her on that. But in my mind, when medical necessity dictates it, you know, I was giving her the recommendation for what was safest for her child. So even though I never really had much of a confrontation with her, I felt like there was a big disconnect between, I thought we understood each other, and then apparently I greatly offended her. (Jackie)

Many times it was not even the students' choice to deviate from the plan; they just had to be the carrier of bad news. Students tried not to take these situations personally, especially since they could relate to the client. Sometimes they had to comfort patients, explaining to them that they did not fail as people just because their birth did not go as well. Students would also support the change of plan with medical reasons, explaining that the baby or mom was in risk or danger. Anna described a time this happened, "I tell them basically that the baby's not tolerating it, and you're not dilating, so you're going to sit here, and eventually the baby is going to get tired, and then that heart rate won't come

back up, so it will be an emergency" (Anna). In this instance, the care that Anna described is one of risk avoidance, rather than an emergency that has already taken place.

Midwifery Students' Emotions

Midwives had a mix of positive and negative emotions regarding their work. Students enjoyed feeling rewarded. This could mean with a patient outcome, such as a woman having a successful birth, or seeing a patient overcome obstacles. Students also liked when they felt they were able to do something for the patient and the patient enjoyed their experience. Catherine explained,

> A perfect day is, I'm able to answer every question the patient has. So they feel like they come in, they get the care they want. My favorite day would be for women to come in and feeling like I was there for them, and they got their questions answered, medically. And that I was holistic. They feel good about coming to their appointment and then leaving. (Catherine)

Students also talked about loving what they do as midwives. "I was having a blast and thinking I'm getting paid for this" (Anna). They felt privileged to share in the excitement of birth with a mother. Jackie described the experience,

> I remember the first time I had a delivery was just *so* exhilarating. I turned to my preceptor and was just like, what we do is *so* incredible. I felt grateful for the opportunity... You're part of this huge momentous day for a family, I just felt really blessed. I felt really, and I don't use that word very often, I don't know... thrilled! (Jackie)

A study by Fraser and Hughes (2007) examining 58 midwifery students' perceptions of motherhood also found that birth was almost universally regarded by students as life changing, special, and a miraculous experience. In my study, connecting with patients and feeling appreciated also brought students joy.

Students also felt a variety of negative emotions. When student were busy or had to switch between a variety of patients, they described feeling "drained, burnt-out, tired, exhausted and overwhelmed." Losses or bad birth outcomes were especially hard for midwives. Samantha disclosed,

> I would say my most difficult deliveries as a labor delivery nurse are... when they come to the unit and their babies passed, and they have to go through a labor to deliver the dead baby. That's intense. You actually have to go through a labor knowing that your baby is going to deliver and not be alive. We have other deliveries where you don't know if they're going to survive... moms and babies aren't supposed to die. (Samantha)

Sometimes students did not directly deal with death, but had to work with other nurses who did, "It was really hard to watch my nurses go through that. I was glad that I could be there as a support person" (Samantha). Emergency situations in general were also stressful for students.

Samantha recounted a time that this happened. "We didn't know who she was, her medical history, or how many weeks she was. All we knew was that she was seizing and that we needed to get the baby out. I left work, I left that operating room shaking... that's life threatening. That mom or baby could have died" (Samantha). Students talked about not expecting death or losses in the labor and delivery unit. A student who previously worked in an ICU unit said that she was more expectant of it there, because it was more the norm. Students felt a certain responsibility for their patients' care and their outcomes, which could be stressful or overwhelming. Some students described feelings of wanting to give up or quit, especially during an emergency. At the same time, they had to keep composed, "You have to be stoic and calm but you're screaming inside" (Kelly). When bad birth outcomes did happen, students questioned what they could have done wrong, or

if it was their fault in some way. At the same time, they had to comfort patients who may be feeling similar emotions.

Whereas students had a good day when they felt they could help their patients, a bad day might be the opposite experience. Anna described,

> I guess there are different kinds of bad days. There are bad days where you're just so stressed all day, and your patients end up getting C-Sections. You just kind of feel like nothing you did could help, and you feel kind of, I don't want to say helpless, but you feel kind of like it was a futile attempt. Nothing went your way, or the patient's way. (Anna)

Conflicts with co-workers were also difficult, especially when it came to conflicts regarding care. Samantha recalled, "It's hard sometimes. It's tiring. Because you want to do things the right way, and you want to do things the way evidence-based practice shows the right way to care for your patients, but I mean, I get beat down a lot at work" (Samantha). Other students described conflicts as "disheartening," "disappointing," or "frustrating." In situations where there was conflict, students had to decide whether to speak up or not.

When patients were around, this could be difficult. "I'm never going to create a conflict or an inappropriate situation ever in front of a patient. If I had a problem with how I was being instructed or something, or if there was conflicting information, I would more likely address if afterward" (Heather). Some students thought they might not have the authority to do so. Anna disclosed, "I haven't gotten to the point where I've ever thought about saying anything to anybody. I don't know if I eventually will. I don't know if that's my place anyway, to even go there with anybody. But it's frustrating" (Anna). Others were more forthcoming, "I'm the type of person that I say what I want, and I stand by my practice" (Samantha). Students spoke of finding a balance between the two, "I

guess you have to learn the balance to know when to speak up and what to speak up about" (Catherine). What happens if something is actually said?

Molly recalled her experience in such a situation, "I said to her that the other preceptor that I'm normally with doesn't have me do it like that. I don't think that was received very well" (Molly). Molly described that situation as a power struggle between her and the preceptor. She believed she was correct in her way, one because it was supported by evidence-based practice, and two, because she trusted her other preceptor. Still, she did not get a good reaction from the mentor that she defended in that case. Her original preceptor told her, "You shouldn't have said that to her, no preceptor likes to hear that they're wrong or a different preceptor told you to do it a different way" (Molly). The preceptor in that case also gave reasons for why the other midwife might have done it differently, defending the other's practice instead of the student's and her own. This situation might have been unique, because the student who spoke up knew that she would not have to deal with the preceptor she disagreed with again.

Students might also have to quash their emotions when it came to patients they did not get along with. Anna remarked, "It was just an awkward experience, I just kind of had to shut my mouth. I didn't want to say what I was really thinking, so I think there's many times where I've had to bight my tongue and not say things that other people might say. What I'm really thinking in my head" (Anna). Students also talked of times where they were warned about a nasty or difficult patient. In those instances, students attempted not to be so judgmental, at least not before they had met the patient themselves, so as to not go into the room expecting a bad outcome. Students tried to be understanding of why

patients might be so frustrated, or were extra nice to them in order to help break through. Sometimes, students were not able to control their emotional responses, which often carried over into their personal life. Samantha clarified,

> A lot of people are big advocates of not bringing their work home with them. I mean, I think that's fine to say when you're a banker or a computer guy, or something like that. But there is no way that you can be at work and help a mom deliver her non-viable baby, or help the mom push for three hours and then have to go back for a C-Section when that's the *last* thing she wanted. You can't do that and go home and not think about that. You just can't. It's impossible. I would say one of my downfalls is I let work effect me and I let what I do effect me overall in life. But I think that also makes me a better practitioner as well because I feel like I can actually connect with my patients more, and be more empathetic towards them. (Samantha)

Students described getting burnt-out if they were not able to deal with their emotions. They were able to do this in a variety of ways, although it was not always easy.

Students did not only have to deal with emergencies or conflicts of care. They also took on their patients' problems and challenges. Students talked about learning to not feel responsible for their patients' lives, or for care they could not deliver.

> I can think of several patients off the top of my head who have very challenging lives. Sometimes we're able to provide extra resources for them, and that makes me feel like other people are taking care of them. Rather than it's just my burden because I care for them. Also, knowing that patients are resilient, and it's not the end of the world because they're going through what they're going through, but they're just going through a hard time. (Michelle)

Midwives often used referrals to deal with medical problems beyond their scope of practice, or found social resources which could help patients. Students talked about learning where to draw a line regarding their own responsibility for a patient's care, "I just feel like learning how to have a healthy boundary, in terms of like how much patient's trauma or whatever to take on. While still being able to be empathetic and provide support to her... I don't know if I will ever have it perfect" (Michelle). Some

students were able to learn this from a preceptor, and were assured that "you can't be responsible for everybody's health" (Samantha). Students reminded themselves that despite giving the best care, some things were beyond their control. Students believed that patients also had to also take responsibility for their own health.

Students said they learned to go through emotions or learned how to cope and move on. Sometimes students alleviated their stress by talking it over with other people. This could mean mentors or other preceptors, or fellow nurses. Students said they were better able to share with people who were in the medical field or who were familiar with medical terms. Despite this, students did still speak to friends, family and significant others. Some students wrote in journals or kept accounts of deliveries and baby's names. Students not only shared negative feelings, but feelings of excitement and enjoyment as well. When it came to negative school experiences, students often found comfort in talking their problems over with other students. It was easier to know that others had dealt with the same kinds of problems or had similar feelings. Michelle suggested,

> I guess one thing I think about is that I think midwifery programs need a formalized way to vent. I think that students need a place to talk about their clinical experiences in a safe environment, without faculty, without preceptors, where we can actually support each other to deal with the challenges of clinic. I learned that I'm not the only one that has these problems, which is a huge relief. I thought that I was being picked on. But it depends on having time and developing friendships, and not all of that will happen organically. (Michelle)

Students talked about having to develop a thick skin or strong attitude. Samantha explained, "Assume the daggers, I'm ready for them" (Samantha). When conflicts or emotions were too much too handle, a student might have to deal with it formally. She may report an incident to her mentor, the school administration, or to a manager in the unit. For a loss, a social worker on site may come speak to caregivers, while other

students talked to their personal therapists. For students, being able to deal with their emotions was not easy, but became more bearable with time and experience.

CHAPTER THREE

IN WHICH THE ARGUMENT CONCLUDES

There is no doubt that students in this study felt a mixture of different emotions, and managed them in a variety of different ways. Using Hochschild's theories of emotion work (1979) and emotional labor (1983) was undoubtedly helpful in the analysis of student emotions. Although I believe that Hochschild's ideas were the best choice for analysis, her theories were not a perfect match, and had to be adjusted to accommodate what was happening within the data. According to Hochschild (1979; 1983), emotion work happens during human interaction, or when individuals adjust their emotions according to the situation. Students in this study were constantly changing and adjusting their emotions, for example when dealing with patients. Students spoke of giving individualized emotions to each patient, or having to switch between two patient extremes, (i.e. a loss and a birth). However, emotions are guided by what Hochschild calls feeling rules, or social norms that help guide and interpret how one should handle themselves during interaction (1979; 1983). What this means is that interactions between patients and students, or students and other midwives, and so on, are not entirely up to the individuals involved. There are other considerations to be made as well. This is especially true when emotion work moves to what Hochschild calls emotional labor.

When emotion work is performed for a wage, Hochschild (1979; 1983) and other researchers refer to it as emotional labor. In her original analysis in *The Managed Heart*,

Hochschild (1983) uses flight attendants to access the world of emotional labor for the first time. Flight attendants, as she explains, used their own emotions to keep passengers feeling safe and happy. This was the case even if they were not feeling the positive kinds of emotions needed for the job. Instead, they often felt stressed, burnt-out, and even disrespected by passengers, but still they kept smiling. Protocols on how to deal with passengers (and the flight attendants' own rising emotions) were established through training materials and seminars that trainees attended. In Hochschild's (1983) analysis, it was in the best interest of the airline to keep the customer happy. Rules and expectations regarding employees' emotional expression were both explicitly stated by the company, and known by the flight attendants who actively engaged in this work as part of their job.

Midwives also use their emotions to comfort and interact with patients. However, unlike the flight attendants in Hochschild's (1983) original analysis, midwives are not instructed directly by their employers (often a hospital) on how to make sure that patients are well cared for emotionally. Instead, the students' strong conviction in giving emotional care was driven by their philosophy as midwives, or their belief in holistic, individualized, patient centered care. They were able to learn this type of care from other midwives who were supportive of this philosophy. Although there is no doubt that comforted and happy patients were a boon for the hospital, emotional work and care of patients was neither valued by the administration as a true skill or as an important and essential aspect of the job. (However, it can be expected that most jobs have at least some guidelines regarding professionalism when dealing with the public.) Instead, a more medicalized model was valued, where midwives often met demands and obstacles that

prevented them from giving emotional type care in a hospital. Students knew that it was the goal of the hospital to make money, and they often felt pressure to turn patients over quickly, giving them little time to develop emotional bonds or to give emotional care. In the hospital, technical skills and training were seen as more superior by doctors and other staff than those of intuition and emotion.

In this way, students ended up having to do two kinds of emotion work or emotional labor as midwives. One, in the way that they gave emotional care to patients, and two, in dealing with emotional constraints and conflicts, sometimes keeping them from practicing in the way they felt they should. When dealing with conflicting models of care, midwives had to adjust their own emotions to each situation, between when emotional care was valued (under the midwifery model) and when it was not (under the medicalized model). Students also had to address different feeling rules for different roles, such as when switching between nurse and provider. Differing models of care between midwives and doctors (and the hospital policy they help write) sometimes created conflicts, resulting in a whole new set of emotions for both students and patients. Switching between different preceptors (also with differing models of care), could be stressful for students as well. To deal, they learned to be adaptable. As a result of all of these complexities (i.e. caring for patients while dealing with conflicting demands regarding emotion work), students described feeling frustrated, overwhelmed and burnt-out. They then had to address these emotions while caring for the patient's at the same time. However, there were times that students were also able to escape the grasps of the

organization, and were able to deliver the type of care they wanted. It was often at these times that students found pleasure and satisfaction in their work.

Wharton (1993) claims that too many researchers of emotion management have only examined the negative consequences of emotion work or emotional labor, first brought to their attention by Hochschild in 1979. Hochschild (1979; 1983) claims that if workers too often put on a show of emotion for the benefit of the organization, there is a danger of estrangement from the self. It becomes stressful for worker to display emotions that they may not actually feel. This was very true for students when dealing with conflicting models of care. However at other times, students found great enjoyment in their work. In Wharton's (1993) quantitative study of bank and hospital employees, she found that, "All else equal, workers employed in jobs involving significant amounts of emotional labor are no more likely than other workers to suffer from emotional exhaustion" (p. 218). In fact, Wharton (1993) goes on to say that, "emotional labor is positively related to job satisfaction" (p. 218). She ultimately finds that it is only under certain conditions while doing emotion work that emotional exhaustion occurs.

Wharton's (1993) report is supported by many of the findings in this study. Wharton (1993) found that higher job autonomy leads to both higher job satisfaction and less emotional exhaustion. She says, "Emotional labor is significantly less aversive among workers who have greater job autonomy" (1993:220). Likewise, students found pleasure in their work when they were able to practice "true" midwifery, and when they felt they were able to make a difference for their clients. In order to do this, it required the autonomy and ability for students to go beyond what the organization required of them.

Wharton (1993) also found that longer working hours and longer job tenure resulted in higher reports of emotional exhaustion. More hours at work also meant less reports of job satisfaction. Although in this study it was not clear whether amount of hours worked played a part in emotional exhaustion for students, at least one student did describe how working a 24 hour shift could be both physically and emotionally exhausting. Other students recounted needing time off from work to relax and rejuvenate. Issues regarding work hours and job tenure did however match reports of students who described some preceptors as better mentors than others. Students characterized some preceptors as more medicalized, less patient centered, and having bad teaching abilities. One reason given for this was that some preceptors seemed overworked, worn out, and close to retirement.

Wharton reports that younger workers are also more prone to emotional exhaustion. Although she does not explain how or why it is that younger workers are more likely to report this phenomenon, the gaps may be filled in by results from this study. Students are still in the learning stages of their career, and have not yet mastered the art of emotion management. They are still novices as midwives, both in the places that they are learning to work and to other staff that work with them. Reports from the data suggest that emotional skills are built over time with repeated experience, and from watching and learning from preceptors who teach them how. This is supported by Wharton's (1993) claim that those who score higher on self-monitoring have less adverse affects resulting from emotion work and higher levels of job satisfaction. Higher self-monitoring meant that workers were more selective about how much they allowed themselves to get emotionally involved at work. Those scoring low on self-monitoring

were more likely to experience emotional exhaustion. In this study, some students directly said that they had to learn where to draw the line at work. Others talked of different skills that they were able to acquire, which helped them deal with their emotions at work. Examples of this include referring patients out, talking to others, developing a thick skin, or placing some of the responsibility on the patient.

In Wharton's (1993) final claim, she finds that higher job involvement is related to higher levels of emotional exhaustion, although these results were not statistically significant. At the same time, higher job involvement was also related to greater job satisfaction. Though these results may be confusing, they again may be explained by the data from this study. They are also supported by the findings of Bolton (2000). From the reports of students, midwives often felt a variety of negative emotions in dealing with patient care. For example, students felt sad and stressful when dealing with the loss of a child. At the same time, they felt it was part of their job to support the patient. Although it may have been hard, students found satisfaction and enjoyment in supporting the patient, even in difficult situations. Bolton (2000) contends that this extra work may be driven by a sense of altruism within nurses who, in the face of organizational obstacles, still work to give their patients a little more. She explains,

> Though the nurses frequently offer extra emotion work to each other, this is more of an equal exchange. As part of a stable community they are givers and takers of this gift. This is unlike the emotion work nurses offer to patients, which is given with little or no expectation of a return on their investment. (P. 584)

However, I would have to disagree with Bolton's (2000) claims of altruism.

Although there were definitely times that students would go the extra mile for their patients (even if they were never to see them again), there were also cases where

they spoke of difficult or demanding patients that they were unable to connect with. Students also talked about how it was nice to feel appreciated by patients, or to receive something back in return for their care, if only a smile or eye contact. It must be true then, that organizational demands are not the only determining factor regarding emotional labor. Students were also selective in whom and how they would give that care, changing their emotional responses between each patient. Referring to Hochschild's (1983) theory, Bolton (2000) herself says, "The acceptance of the view that, within the social framework, actors can 'do' varying degrees of emotion work, that there is choice in what, when how much and to whom to give, allows the introduction of the concept of the 'gift exchange'" (p. 582). This is further supported by students' reports of self-monitoring, choosing how much or how little to give and worry about each patient. One difference between Bolton's (2000) findings and my own is that unlike midwives, the gynecological nurses in her study most likely delivered more fragmented care. Gynecological work does not offer as many opportunities for patient bonding over long periods of time. Therefore, there may be more incentive for midwifery students in this study to develop more equal, long lasting bonds with their patients in which both parties give and receive in the relationship.

Finally, there is the case then, of what to call what the students in this study are doing, that is, should it be called emotion work or emotional labor? This issue on terminology was first brought to my attention by Hunter and Deery (2009) in *Emotions in Midwifery and Reproduction.* Emotion work is often considered to be a private act, where as emotional labor happens in and with the public. Although all of the students in this

study worked in a hospital, some students said they would like to enter the homebirth atmosphere, therefore taking emotion management into the home, away from the constraints of an organization. Another difference between emotion work and emotional labor is that emotional labor is paid where emotion work is not. Although midwives are paid for their work, students reported times where they saw preceptors work extra hours. Midwives who are on call have to answer to patients at all hours of the day and night. Furthermore, what is to be said of relationships and friendships that develop and evolve outside of work that go beyond the "assigned" duties as a midwife? For my study, I chose to use Hochschild's (1979) original term of emotion work. Although the situations that students are dealing with as midwives do match some aspects of the emotional labor theory, it is clear that the full picture is somewhat different, perhaps meeting somewhere in the middle of emotion work and emotional labor. Emotion work therefore seemed like a more encompassing theory to use as a starting point for this and any further analysis.

Research Limitations

There are a few limitations to consider in this research. This research project is not representative of all midwifery departments and students. Interviews were only conducted with a limited number of students at one site location, and their experiences are not entirely generalizable to all midwifery populations. Furthermore, descriptions of doctors, other nurses, preceptors, and patients were described through and by the students. This project does not claim to give an accurate and perfect account of what those groups were actually like, but rather, how the students viewed them. This project also lacks any observation data in which to confirm student viewpoints. However,

Lofland et al. (2006) claim, "Many social situations (experiencing grief over the loss of someone or something one cares deeply about, for example) may be masked in everyday interaction and thus be directly apprehensible only through intensive interviewing" (p. 18). Because this project does largely center on emotions, interviewing may have been the best option, despite still having difficulties in gaining observations to back up this material.

It should also be noted that the limited number of experiences derived from the interviews were largely supported by reports from other studies. Many of these studies were from the UK, where midwives work under a completely different hospital system called the National Hospital Service, or NHS. The NHS is a public health system, unlike the private system of the US. Despite these differences in context, many of the experiences that students reported in this study were similar to those reported in the UK. At the same time, the eight students who participated in this project were diverse in their own viewpoints. It is likely that other students and departments would also be diverse in their experiences. My hope is that this project begins to unravel those complexities, so as to serve as a starting point for other projects in the same area. Only then can a true picture of what midwifery students are dealing with be established.

Final Word

Midwifery is often misconceived, both among the general public and among the medical profession. Students in this study had a variety of reasons for becoming midwives, and were strong advocates of the midwifery model of care. With that in mind, students came to their training with a number of expectations for their work. Many were

unprepared for the obstacles that they would ultimately face during their clinical training. Students found themselves performing two kinds of emotion management, first in the way they delivered patient care, and second in dealing with the demands of the organization. Dealing with this variety of emotions could be difficult for students. However, students also found enjoyment in their work. The effects of emotional labor varied between different people and under different conditions. Students were also able to establish a limited amount of autonomy under organizational rule, where they were able to decide how and to whom they would deliver more emotional care.

With so many positive attributes associated with midwifery care, whether it be lower costs, better patient satisfaction, or better health outcomes for mothers overall, midwifery work should be utilized and supported on a larger basis. This also means supporting midwifery students, who are the future of the profession. Until preceptors, hospitals, doctors and people in general realize their difficulties, students will continue to enter a career where they strive to deliver a unique and patient centered philosophy of care, instead being misled into an atmosphere that is not conducive to doing so.

APPENDIX A

INTERVIEW QUESTIONNAIRE

How Decided on Career

1. Tell me about how you decided on a career as a midwife.
    - -How did the idea first develop?
    - -How did you go about learning about the field?
    - -Did you talk to someone about it?
    - -Can you tell me about some of your earliest expectations of this work?
    - -What did you think it would be like?

First Days

2. Tell me about some of your first days in the program.
    - -Were there any initial surprises that you experienced?
    - -Tell me about some memorable events or interactions from the first week or so.
    - -Tell me about some memorable feelings you had that week. Can you recall the circumstances that led to those feelings?
    - -Would you say that your feelings from that first week have changed over time, now that you have been in the program for some time?

Participating in Birth

3. Tell me about what it is like to watch or to participate in a real birth.
    - -Let us start with your first birthing experience in clinical training.
    - -Describe the first birth (who was there, how it proceeded).
    - -How did it make you feel?
    - -Did you share these feelings with anyone at the time? Later?
    - -Were there any initial surprises that you experienced?
    - -Do you have to "handle"/carry yourself in any way (during a birth)? Tell me about that.
    - -Would you say that there are ways that you mentally prepare yourself for a birth? How so?

Difficult Birth

4. Tell me about a particularly difficult birth you were present at.
    - -What about that birth was difficult?
    - -Who was it difficult for and how?
    - -How did you feel as it proceeded?
    - -How did you get through that birth?

Successful Birth

5. What about a birth that you remember as being exceptionally successful.
    - -What happened? Tell me about it.
    - -What about that birth led you to consider it a success.
    - -Was there anything different that you did in that birth than usual?
    - -Was there anything different about the birth itself?
    - -How did it make you feel? What about the patient, how did they react?

Strong Emotional Relationship

6. Can you tell me about a particularly strong emotional relationship that you developed with a patient or with a baby?

-What did that relationship entail? Tell me about it.
-How did you take part in that relationship? What was your role?
-What was the response you got from the patient?

Difficult Relationship

7. Where there any times you felt you could not connect with a patient? Tell me about one of these experiences.

-How was it that you could not make a connection?
What were the obstacles you faced in that situation?
-How did you act in this situation? How did the patient act?
-How did you work around those obstacles?

Bad Day at Work

8. Think back to your worst day at work, can you tell me about that?

-Explain what a bad day is like for you?

Best Day

9. What about the best day at work, can you think of a day that you consider your best or most successful day at work?

-What is a good day at work like for you?

Training Put to Use

10. Can you tell me about an experience in your job where your training as a midwife came in handy? That is, a time when training was put to direct use?

-What happened in this experience?
-What aspects of your training came in handy? How?
-Were there aspects of that experience where your training was not useful?
-How so? Did you do something instead?

Improvising

11. Can you tell me about an experience in your job where you had improvise, that is, you had to do something that you were not trained in/prepared for?

-What happened in this experience?
-What did you do that was improvised?
-How was your training not adequate enough to deal with that situation?
-Did you do something instead?

Learning From Clinical

12. Is there anything you feel you have learned directly from your clinical experience? That is, something that you did not learn in the classroom?

-What did you learn?
-How did you learn about it?
-Who taught you?
-How has that helped you in your job as a midwife?

Obstacles Unique to Midwifery

13. Do you feel there are obstacles you face at work that are unique to the job of a midwife? That is, something that is not experienced by other types of medical practitioners?

-Can you think of an example or story to tell me?
-How is it different?
-How do you deal with those obstacles?

Nursing vs. Midwifery

14. Can you tell me in what ways the job of a midwife is different than that of a labor and delivery nurse?

-Can you think of an example or story you experienced?
-How is it different?
-In what ways?

You mentioned _____, could you tell me more about that?

Did _____ happen?

Was _____ a consideration?

How did you handle that situation? / How did that make you feel?

What would you consider the proper way to handle such a situation?

Do you have any formal procedures for these kinds of situations?

Would you say that _____?

How likely would you say that _____?

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VITA

I earned my bachelors degree in Sociology from Loyola University Chicago in December 2007. From September to December 2007, I volunteered for the Student Life Working Group under Dr. Talmadge Wright, where I helped to develop a study that would examine students' perceptions of Loyola Food Services. In August of 2008, I began working on my master's degree at Loyola on a part-time basis. I was also employed full time at a property management company from August of 2008 to February 2011, until I began working on my thesis project. I presented my thesis project under the title, "Examining Emotion Work with Midwifery Students in Clinical Training," at the Midwest Sociological Conference in April 2012. After earning my masters degree in Sociology in August of 2012, I will be moving on to Kent State University in order to earn my PhD in Sociology.