Negotiating the Normal Birth

Norms and Emotions in Midwifery Education

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1. Introduction: Learning norms in midwifery education

“It is usually normal and you should let it be normal,” said the midwifery teacher about pregnancy and childbirth. When I asked her to explain what is normal, she said, “It’s hard to tell what is normal; it depends on who is judging it.” (Interview, January 23, 2009)

The quote above is from my interview of a midwifery teacher at an early stage of my field work in Swedish midwifery education. The issue of normality caught my attention. It seemed complex and not self-evident, just as the teacher pointed out, and worthy of further investigation.

Pregnancies and childbirths are not just biological or medical events. Birth is an interactive process between biology, psychology, politics, society, medicine, and technology (Jansson 2008: 14). Childbirths are also emotionally intense situations, not only for the parents-to-be but also for those who work in delivery care (Hunter 2001, Jonvallen 2010). In addition, pregnancies and childbirths are sociocultural situations; there are norms about the normal birth.

In the quote above, three dimensions of normal are brought out by the midwifery teacher. First, it depicts the most common one: “It is usually normal.” Second, a norm concerns the ideal: “You should let it be normal”. Norms are furthermore context-dependent; whether to perceive a pregnancy and birth as normal “depends on who is judging it”, as the midwifery teacher pointed out. In other words, “... a norm prescribes or expresses an ideal pattern or standard of behavior in a given social group or social context to which conformity is expected” (Siegetsleitner 2006: 1750).

In this study I investigate these three aspects of norms about the normal birth and how midwives should encounter the birthing woman and the delivery. Given that birthing is an emotionally demanding and complex

situation, my focus is on feeling norms in delivery care. Delivery care is characterized for the midwives by short and intense encounters with birthing women, which means that a midwife needs to quickly get a picture of the status of the woman and the delivery. Thus, it seems important that future midwives learn not only the medical and technical aspects of their future profession but also how to encounter patients' feelings and how to handle their own feelings in a "proper way", that is, one that ensures a birth as normal as possible.

Accordingly, the *main aim* of this thesis is to show what norms about a "normal birth" and how to encounter it are present in and understood by students in midwifery education. More precisely, the study explores how midwifery students together discuss how to handle birthing situations and negotiate what feelings are considered "right" for a midwife to show in encounters with birthing women, and how births "normally" evolve.

The questions I pose are the following:

- How do the students talk about how to define normal birth? What kind of norms about normal birth can be elucidated through their discussions?
- What kind of potential deviations from normal birth did the students discuss and how did they talk about how to handle them? In what way were norms about normal birth made part of the students' discussions about deviations?
- In what ways can norms about feelings be seen as part of norms about childbirth and how should those situations be handled in the professional role of a midwife?

To answer these questions I have made an ethnographic study of Swedish midwifery education. I have participated in and audio-recorded collaborative group sessions. Thus, I have focused on situations where the students came together as a group and discussed both normal and complicated pregnancy

and birth. The collaborative group discussions are only one part of the midwifery student's education, but it is an important part from this thesis' perspective, as this is a central occasion when students discuss their experiences from delivery wards, their expectations about their future work, and how they should handle difficult situations in a proper way. It is also organized as a central and characteristic part of midwifery education. My choice to focus on the students' discussions of birth and delivery, rather than choosing another or all areas of midwifery, was in line with the understanding that midwives' main work is to help birthing women. Accordingly, these areas constituted most of the courses in the midwifery education program.

The thesis draws inspiration from research about how normality is constructed within healthcare (e.g. Martin [1987] 2001, Sandell 2001), about norms of feelings in the work role (e.g. Bolton 2000, Hochschild [1983] 2012), and how categorization work/prognostication that professionals must learn in order to handle complex situations (e.g. Mesman 2005, Mäkitalo 2012, Strauss 1978, 1985) can be understood and negotiated. I use a situated learning perspective to approach how students together learn and practice how to discuss different birthing situations as midwives (Lave & Wenger 1991). I also relate my study to some previous studies of midwifery and midwifery education, which will be discussed later on in this introduction. First, however, I will give a brief picture of midwifery and childbirth in Sweden, as well as of midwifery education.

Midwifery and childbirth in a Swedish context

Swedish midwives work with women in different stages of life. They work in delivery wards, maternity wards, midwifery clinics, and gynecology wards. They give advice to, and care for women during pregnancy, delivery, and menopause. They also help women with contraception and do Pap smears and tests for venereal diseases. Nevertheless, pregnancy and birth constitute midwives' main work.

In Sweden, most childbirths take place in delivery wards in hospitals with one or two midwives and an assistant nurse in attendance. The birthing

woman is expected to bring someone with her, typically the father of the baby, who is to actively support the woman through labor, offering encouragement and massage to ease the pain. When they arrive at the delivery ward, a midwife examines the woman in order to establish the baby's position. This is done with palpation, an abdominal examination, in which the midwife moves her hands along the woman's belly. She also conducts a vaginal examination where she measures the cervix's dilation and further establishes the baby's position. The midwife also times the contractions and checks the baby's vital signs with the help of various technical devices.¹ If the midwife determines that the woman is in labor (that the contractions are not only practice contractions and that the cervix is dilating), she registers the woman as a patient in the ward.

The woman stays in the same room – the delivery room – from when she is admitted until the baby is born and has been weighed and measured by the midwife. Thereafter mother and child move to a maternity ward. If there is a bed available, the partner is invited to stay overnight. How long they stay in the maternity ward depends upon whether the birth was a vaginal birth or if the baby was delivered with a caesarean section, the health of mother and child, and whether the woman has given birth before. The hospital stay for

¹ The technology I refer to includes Cardiotocography (CTG) and STAN, apparatuses that register the mother's contractions and the baby's heart rate. CTG can be described as a surveillance technology that monitors the woman's uterine contractions and the baby's heartbeat. A simple explanation of the technology is that a midwife can to some extent, based on the graphs, estimate progress (the woman is supposed to have three to five contractions per ten minutes to be in active labor) and how the baby responds to the woman's contractions (the baby's heartbeat often drops during a contraction but is supposed to recover in between). The students spoke of STAN as even harder to learn than the CTG. One reason was that it is not to be found in all delivery wards. STAN works as a CTG technology but has an additional function and was developed to reduce the amount of unnecessary caesarean sections. STAN is supposed to recognize the healthy babies that the CTG cannot. There is an ongoing debate about STAN, both concerning the development of the technology and research process as well as the usage of it (Jonvallen 2010).

women who have been through uncomplicated vaginal births usually lasts between one to three days (*The National Swedish Board of Health and Welfare* 2001).

From one point of view, patients whom midwives encounter in delivery wards are much alike; they are of a fertile age and are in the ward for the same reason, to give birth. From another perspective, delivery wards gather women from different segments of society, different backgrounds, and with different experiences. The encounters between patient and midwife are short, which necessitates fast decisions about what kind of patient the midwife has been assigned to. The midwife quickly needs to find an appropriate approach, based on whether the patient is mentally stable, if she has previously experienced the loss of a child, and if she has other cultural understandings about the body or birthing process of which the midwife should be aware. When the midwife ends her shift, she will probably not see this particular patient again.

Even though women in Sweden have the formal right to decide how they want to give birth, midwives and doctors encourage vaginal births and aim to decrease the amount of caesarean sections (Waldenström 2007). There are some regional differences but choices other than vaginal births in delivery wards, such as caesarean sections for what is described as non-medical reasons and home births, are often questioned by those involved and by medical practitioners (Hellmark Lindgren 2006). Unnecessarily increased risk is the main argument against caesarean sections for non-medical reasons (Hellmark Lindgren 2006: 159ff). Planned home birth is possible in Sweden but highly regulated and unusual, in contrast to countries like the Netherlands, where home birth has been given a more significant role in midwives' practice (Davis-Floyd et al. 2010). In Sweden, there has not been any significant return to home births, in contrast to countries like Japan during the 1990s (Matsouka 2010). What has been debated much more in Sweden are dimensions of pain: normal pain, pain-free deliveries, pain relief methods (both pharmacological and non-pharmacological) and technological surveillance during the labor process (Jansson 2008).

Monitoring technology is always present today in delivery wards in Sweden but the extent of its usage differs. It is applied as a procedure that both assures normality and detects deviations. However, this does not mean that all midwives look upon technology as indisputably good. According to Alan G. Barnard and Marlene Sinclair (2006), who claim that technology creates a physical distance between the midwife and the patient and moreover that “The technology embodies a sense of control, of taking charge, of being with, but also of being distant” (2006: 581ff). Swedish sociologist Diana Mulinari argues that computerized surveillance of patients has resulted in having midwives spend less time in the delivery rooms with the birthing women and more time in what she calls the computer room (2013: 121).

In midwifery and in the midwifery education program, pregnancy and delivery are divided between normal and complicated.² Students are told that a normal birth is a vaginal birth that starts spontaneously and is characterized by taking place after a full-term, low-risk pregnancy. In the midwifery students’ course literature one can read that the baby in a normal birth is born headfirst and the placenta is expelled within a reasonable period of time. In addition, the wellbeing of the mother and child should be satisfactory (Faxelid et al. 2001). This definition of normal birth is established by the *World Health Organization*. The complicated birth, on the other hand, is characterized by increased risks, such as multiple births, induced labors, and different states of illness. What is considered a normal or a complicated birth and how to handle it is, however, more complex in practice. It may include considerations of pain relief as well as estimations of possible vaginal ruptures during the expulsion stage of the delivery. A patient’s social character and lifestyle, history, and behavior are also included the estimation of what may be a normal pregnancy and birth. Even what is considered a normal pregnancy or childbirth may change because of a sudden turn of events, like a severe

² These definitions were applied at the midwifery education program and I consequently use them when writing about pregnancy and childbirth. When the students discussed, for example, CTG graphs (see footnote above), they added an additional term, pathological. This meant that a graph could be termed normal, complicated/divergent, or pathological.

bleeding or if the patient panics. These various aspects will be considered in the chapters that follow.

A decision on whether a pregnancy and birth is categorized as normal is not only about perception of risk. In Sweden, it is only when midwives detect a deviation that doctors become involved. The distinction between normal and abnormal pregnancy and childbirth, and the assumption that the distinction can be made, Kerstin Sandell calls "... one of the central activities in medicine" (2010: 30). It involves a decision about whether the person/patient should be treated or not. The distinction between normal and complicated birth determines who is in control. When a midwife defines a pregnancy or delivery as abnormal doctors will take over the responsibility of the patient (in cooperation with midwives). Doctors are only included in my study when they, or their actions, were part of a students' experience-based stories from clinical sites.³

Swedish midwifery education

Midwifery students in Sweden receive a university degree equivalent to a master's degree. Such programs are given at twelve universities/university colleges in Sweden today. *The National Swedish Board of Health and Welfare* (2006) has established the qualifications of midwifery and what midwifery students need to learn. These directions are incorporated into the school's curriculum and formulated as goals that students must attain to become authorized midwives. One of the requirements for admittance is the experience of working full time as a registered nurse for at least twelve

³ When students mentioned other professional groups with whom they work, doctors were the ones mentioned. The students spoke of doctors as experts with whom midwives cooperate, in complicated labors, for example, and their mere presence in the ward was described as reassuring. However, doctors were also spoken of as not considering social aspects, which according to the stories told by midwifery student was very problematic. There is an additional professional group working in delivery wards – assistant nurses –but they were only spoken of once or twice. What the mentors during practical training did and said was much more of a topic discussed by the students.

months. The nursing program is a three-year university education and the midwifery education can thus be seen as a supplementary education. However, the midwifery students objected when I spoke of their education in this way. They emphasized that midwifery is another profession, not a specialization within nursing, unlike an anesthesiology nurse or a district nurse. Teachers and students in the midwifery education program that I observed spoke of becoming midwives as a change of profession. What that entails in terms of feeling norms and ideas of the normal patient is something that will be discussed in this thesis.

The midwifery education program covers three semesters and includes both practical training at clinical sites and university-based education. In the midwifery education program where my field work took place, each semester contained two five-week long periods of practical training when the students, under the guidance of mentors, practiced in delivery wards, maternity wards, and midwifery clinics. Lectures, group sessions, and seminars dominated the other part of the education. I do not wish to dichotomize practical and theoretical training and hence will call the latter “university-based training”. Theory and practice are intertwined in both settings, and neither one of them stands alone. Theoretical knowledge was applied in clinical settings and practical work was discussed in the schooling environment.

The midwifery education program observed in this study applied Problem-Based Learning (PBL) as its main pedagogical approach.⁴ This is a teaching method originally developed by Howard Barrows (1980), a physician and medical educator. He aspired to get the students active in searching for information and practice a professional reasoning through discussing authentic cases, instead of just being told what to do and what to learn. It is a student-centered teaching method and it builds to a great extent upon group-based learning. The fact that PBL was applied at the midwifery education program where I conducted my study meant that there were many collaborative group sessions scheduled during the university-based part of the education. Group activities such as collaborative group sessions constitute the core of my

⁴ PBL is quite common in medical education in Sweden.

analyzed material, but I have also been present at many other parts of the education. The curriculum also included lectures and seminars as well as clinical skills practice. The students trained different procedures, such as examining placentas or practicing deliveries on birthing simulators. Lectures either introduced subjects or gave in-depth perspectives, often in combination. Occasionally other professional experts taught; for example an obstetrician held lectures on how to use and interpret Cardiotocography (CTG) and STAN technology and an ethics researcher spoke about ethical dilemmas. But most teaching was done by three teachers who worked in the midwifery education program, and who have been interviewed in my study.⁵

Most courses at the midwifery education program were oriented towards pregnancy and delivery care, which meant that a lot of time and discussions revolved around these matters. The first semester dealt with normal aspects of pregnancy and delivery, with the aim, according to the teachers, that the students should learn to see the normal instead of searching for deviations. During the second and third semesters, students took courses on prevention within reproductive, prenatal, and sexual health and spent increasing time on their master's theses.⁶ The main theme during the second semester concerned complicated situations in pregnancy and childbirth. This was the semester teachers and students spoke of as the most emotionally challenging period of the education.

Previous research about midwifery work and education

Several studies about midwifery and midwifery education have inspired me when writing this thesis. There is a wide range of studies about midwifery but

⁵ An additional teacher started while I was doing my field work but I did not interview her.

⁶ The students who wrote their theses during the time of my observation chose to specialize in areas that concerned delivery care, maternity care, or the work in a midwifery clinic. Subjects included, for example, first-time fathers' experiences of birth, women's sense of control during the labor process, and young women's experience of gynecological exams.

less research on midwifery students and education. I will present some research which contributes with a background to my study and situates my analysis of norms about normal births and professional feelings in midwifery.

I have chosen to focus on three themes that relate to my research. These are: perceptions of risk in relation to the understanding of what constitutes normal pregnancy and childbirth, perspectives on pain and technology use in delivery care, and midwifery education and learning. Studies about midwifery in the social sciences⁷ often either investigate the interactions between midwife and patient or between midwife, technology, and patient. The studies taken up here concern societies that are similar to Sweden's, and address questions that have been relevant to the students and to the aim of my thesis. I have thus only included studies from prosperous, highly developed countries. This was not my original intention. However, as it turned out, studies about midwifery differ widely in what is problematized and investigated, depending on where the studies have taken place. The standard of living in a society, as well as mortality during pregnancy and birth and the access to medical recourses, seem to highly influence the object of study.⁸

Decisions in delivery care are greatly influenced by perception of risk. This determines the choice of vaginal birth or a caesarean section and whether

⁷ Of course, not only researchers in the social sciences and humanities study midwifery. In addition, there are healthcare research and midwifery research. Midwives themselves study areas within midwifery, but mainly focus on problems that they encounter as midwives, rather than studying how midwives carry out their work. Thus, Monica Christianson has examined risk-taking among young women and men in relation to venereal diseases (2006), and together with Carola Eriksson studied myths about the hymen (2011), and the experiences of fathers-to-be of their partners' being offered HIV tests during pregnancy check-ups. For midwives who work at midwifery clinics, these are probably situations they encounter in their everyday work. Interesting research has also been conducted by Birgitta Salomonsson (2012), a midwife who has studied how midwives perceive patients' fear of childbirth. Her results show that midwives who work at midwifery clinics feel inadequate in handling patients with extensive fear of pain, and requested complementary training. Midwives working in delivery wards, on the other hand, felt that they could help these women.

⁸ See, for example, Abimbola et al. (2012) who write about the importance of reducing the high numbers of maternal mortality in Nigeria and the need of making midwifery expertise available.

the birth will take place at home or in a hospital. Different birthing situations involve more or less risk; however, risks may be estimated differently. Hence, what might be seen as objective medical decisions are culturally contextualized. Research from Sweden and the US as well as a comparative study between France and the Netherlands might serve to illustrate this.

According to a study by Birgitta Hellmark Lindgren (2006), vaginal birth is seen in Sweden as implicating the lowest degree of risk. She has used the concept “pregnoscape”, inspired by Appadurai’s “ethnoscape” (Appadurai 1996), to describe contradictory perceptions between midwives and the birthing woman about the pregnant body, and shows how the woman through her body often becomes subordinated to technology, and to the biomedical norms and knowledge represented by the midwives. Even though Hellmark Lindgren shows that vaginal birth is the preferred outcome within Swedish healthcare, she argues that delivery care is culturally constructed and thus changeable, which opens up the possibility that the situation may change in the future, and cesarean sections may become the new norm (2006: 235).

Margareta Bredmar (1999) has also focused on the interaction between midwives and the pregnant women. She studied pregnancy check-ups at midwifery clinics in Sweden and used communication analysis to depict how midwives drew upon discourses about pregnancy as normal when they spoke with the women. Through what Bredmar calls normalizing processes, the midwives in her study made normal what patients experienced as strange and abnormal. She also shows how midwives used questions in a specific way to approach sensitive subjects such as alcohol habits. For example, when talking about unhealthy habits, midwives said “we recommend” rather than “I recommend” and thereby tried to influence the woman’s behavior without breaking societal norms of not intervening in the other person’s personal life. I see an interesting aspect here that relates to my study – how the midwifery students discussed how to approach patients in difficult situations without being judgmental.

My study – just like the ones by Hellmark Lindgren and Bredmar – proceeds from the assumption that what is seen as normal birth and what is estimated as low or high risk differs depending on context. Perceptions of

pregnancy and delivery care have also changed several times over the years. Christina Jansson (2008) has identified several conflicts within Swedish delivery care between 1960 and 1985, a period when gender equality debates flourished in society and also influenced birthing practices. Hence, norms about birth reflect not only medical concerns, but social debates as well.

Anthropologist Emily Martin contributes that normal birth is culturally constructed by elucidating norms about the female body. Martin has studied how the pregnant body is shaped and perceived within medicine ([1987] 2001). She describes a different context from that of Sweden, where vaginal birth and caesarean section are estimated differently. In Martin's study of birthing women in the US she shows how they struggle for their right to vaginal birth. They want to avoid medicalization of birth and caesarean section. This is in clear contrast to the Swedish situation where vaginal birth is the norm and it is difficult for a woman to have a caesarean section by choice and without what is seen as good medical reasons. Martin further questions how normality and the female body are perceived in terms of regularity. She gives the example of how an irregular menstrual cycle is in general seen as deviating. This perception of regularity as desirable also dominates Swedish pregnancy and delivery care.

Studies by Hellmark Lindgren, Bredmar, and Martin have been important for this thesis in two main ways. First, they show how norms and ideals are culturally constructed and how the medical/midwifery perspective does not necessarily correlate with how pregnancy and birth is perceived by the pregnant and birthing women. Secondly, they have explored normative understandings of how normal childbirth should occur, something which I will discuss in connection to how these understandings are negotiated in the midwifery education program.

Other studies from which I draw inspiration show how the perception of risk in pregnancy differs between social contexts and over time. Madeleine Akrich and Bernike Pasveer (1998, 2004) have studied childbirth in France and the Netherlands and show important differences in what is considered normal and risk-free. In France, births mainly take place in hospital settings and with a high rate of pharmacological pain relief. In contrast, birth pain is in

the Netherlands seen as something normal that women may suffer from, but can handle. The perception of childbirth pain as manageable and not constituting a crucial risk is one reason for the high number of home births in the Netherlands.

Jansson (2008) has identified several ongoing conflicts within delivery care, where different perceptions of risk are central. For example, birthing-pain discussions include different emphases on risk, where the risks of not easing the pain are contrasted with the risk of using pain relief methods. Thus pain in childbirth – my second theme – has been the subject of much discussion within delivery care, in Sweden as well as elsewhere. It is an ongoing discussion with different stances held by different midwives. Mulinari (2013) has analyzed this discussion in a contemporary perspective, based on field work in a delivery ward. She found two main approaches among the midwives studied, which she calls respectively traditional midwives and risk-oriented midwives. While the traditional midwives saw birthing pain as something women could bear as long as they accepted it as normal, the risk-oriented midwives focused on defining pain as either normal or pathological. Mulinari criticizes these standpoints for being either “essentializing, moralizing and patronizing the women and their births”, or “instrumental, one-dimensional and reductionist” (2013: 129). She argues that midwives expect women to express pain in a way that accords with the midwives’ own opinion about the role of pain, that is, how women express pain can be related to the delivery’s progress. But experiences of pain are cultural, and Mulinari maintains that midwives do not see this. Mulinari’s study is clearly relevant to my discussion in this thesis and I will discuss the similarities and differences between her results and mine in Chapter 7.

The role of technology in delivery care, which is part of my second theme, has been investigated, both historically (Jansson 2008) and today. Studies within this area refer to my second theme. Studies by Judith T. Shuval and Sky E. Gross (2008), Barnard and Sinclair (2006) as well as by Mulinari (2013) show that technology both challenges midwives’ knowledge and decreases the interaction between midwife and patient, as midwives can monitor the birthing work from outside the delivery room. Technology in

delivery care is a contested area. For example, Shuval and Gross found two opposing positions towards technology among midwives in Israel. These include those who apply modern medicine and those who oppose the extent to which technology is used and instead turn to alternative medicine. These findings are relevant for my study because they show different stances held by persons within the same profession and workplace. It opens up questions about if and how students in midwifery education discuss the use of technology and norms about its use, which I further explore in Chapter 4.

In research about midwifery students and education – the third and final theme – most studies have focused on practical training in wards where students learn from experienced midwives.

In a Norwegian study, Gunnhild Blåka (2006) focuses on midwifery students learning practices of midwifery, including ways to approach patients. She looked at situations where students learned from experienced midwives in clinical settings. Blåka claims that it is during practical training in wards that the newcomers learn midwifery, and where they become accepted as competent by other midwives. She argues that midwifery students construct their professional identity primarily among other, experienced midwives. My study, on the other hand, observes students in situations where there were no patients and no mentors present. Nonetheless I argue that students learn about and try to construct professional midwifery approaches in those contexts. What I bring with me from Blåka's study is the assumption that a lot of things happen in the students' learning process as they do their practical training in wards. Her research made me listen closely to the experience-based stories told by the students when returning to the university site, and also inspired me to conduct a group interview about this topic. I was interested in how they spoke about what they had learned and experienced, how they talked about their supervisors and about how the university-based part of the education was perceived in relation to their practical training in wards.

Despite the meager amount of studies about midwifery students' training, there are studies about university-based medical education that are relevant to my work. They bring up several dimensions of learning. One

example is the well-known study of medical education by Jack Haas and William Shaffir (1987). They observed a class of medical students in Canada and focused on how the students adapted to the professional training. This study turned out to be very useful for my last empirical chapter, which focuses on midwifery students' discussion about stillbirths. During the medical education studied by Haas and Shaffir, students often had to confront situations with dead or dying people, which formed a prominent part of their discussions. I use their study to explore professional norms about handling death. However, Haas and Shaffir conclude that neither they nor the students knew what kind of attitudes or approaches they were expected to express in their coming profession. In my study, on the other hand, the right professional attitude was something that teachers and students continuously brought up in the discussions.

Through previous research on the three themes of cultural perceptions of risk in pregnancy and childbirth, contrasting perspectives on pain and technology are elucidated. The research about midwifery and medical training indicates that norms and practices in delivery care are culturally and socially constituted and changeable. However, what I see as lacking in previous research is an analysis of how norms are negotiated in the process of becoming a midwife, including how technology, pain, and the interaction between midwife and patient are brought together to form feeling norms about the normal and the complicated birth.

Outline of the study

This first chapter of the thesis has presented the aims and research questions of my study as well as situated it within midwifery and midwifery education in Sweden. It has also brought forward relevant previous research and the research areas to which this study make a contribution.

The thesis continues with two chapters where I describe my theoretical and methodological approach. Chapter 2 discusses the main theoretical fields from which I draw inspiration and to which I wish to contribute. It also presents the main concepts applied in the thesis. Chapter 3 describes how I

conducted the study. It includes methodological discussions about the decisions I made on the design of the study, the choices made during field work, analysis and writing, as well as reflection about the ethical questions involved in a qualitative study of this kind.

Following Chapter 3 come five empirical chapters, which take up different themes in relation to norms concerning birth, delivery and patient relations. The first empirical chapter, Chapter 4 discusses what is meant by a “normal birthing trajectory” from a midwifery perspective. Here, norms as the statistical, the assumed most common, and as the ideal are tightly interwoven. Chapter 5 develops the concept of feeling norms. This concept is applied in several chapters, either in relation to patients’ feelings or to midwives’ professional feelings. Chapter 5 focuses on the latter, and will discuss midwifery students’ negotiations of proper professional norms of feelings in childbirth situations, and the midwives’ role and perspective during birth.

These first empirical chapters show how future midwives learn the assumption that most births and patients are normal. In the following chapters, I will problematize this assumption through focusing on midwifery students’ negotiations about what a normal birth actually is, and about how to handle (potential) deviations from normality. This involves finding the proper way to encounter diversity in patients and how to relate to patients experiencing birth in a non-standard way.

In Chapter 6, the concept of “predictive marker” is used to show how the students tried to find aspects in a patient’s livelihood situation, previous experiences and feelings towards birth, of which they have to be observant as they may affect the labor process, and make it deviate from the norm of the normal birth. Chapter 7 focuses on norms of childbirth pain, and how it from a midwifery perspective is perceived as good and normal and included in the understanding of normal birth. This chapter also discusses what students learn to do when pain is neither good nor normal and how that affects the understanding of normal birth. The last empirical chapter, Chapter 8, shows how the issue of stillbirth challenges the students’ feelings and perceptions of

their work, but also how they learn that the death of a child sometimes may be perceived as normal and unavoidable.

Throughout the thesis, the norms of normal and complicated births, as well as the negotiated and blurry distinction between them, are discussed in relation to gradually more complex themes. The thesis' empirical chapters begin with a rather uncomplicated categorization of normal birth but continue with the students' more complicated categorization work where they in relation to normal birth negotiate how to handle patient feelings going astray, dimensions of pain, and stillbirth.

In the final Chapter 9, I summarize the main findings of the thesis and reflect upon its contribution to midwifery research and to issues of feeling norms, the normal and the complicated in professional education and work.

2. Theoretical framework and analytical tools

This study is situated in an interdisciplinary research context and thus is inspired by, and participates in, several discussions. It brings together different perspectives on professional training, norms, and feelings in a cultural context. In this chapter, I will present my theoretical framework and the analytical tools used to understand midwifery students' learning of professional norms, especially those concerning how to perceive, act towards, and display the proper feelings to patients and the birthing process.

Situated learning in collaborative group sessions

Even though my study can be categorized as an ethnographic study conducted in an educational setting, my focus is not on learning and teaching, but rather on students in learning situations talking about midwifery practice. Thus, my theoretical perspective on learning is influenced by the kind of learning situations I observed, as well as by the pedagogical perspective called Problem-Based Learning (PBL), which is used in the midwifery education program where I conducted this study.

In the introductory chapter I described how the midwifery education program included both university-based training and training at clinical sites. I explained how the midwifery education program is structured, and elucidated the thematic division between normal and complicated pregnancy and birth that permeates the courses. These characteristics are important to point out because most of the material that I present comes from discussions among students sitting in rooms for group activities, when they discussed what to expect in different situations with patients and how to handle them.

The students' learning in groups is to be analyzed from two perspectives. I will use theories of situated learning, which contribute a wider perspective

on learning in vocational education. But mainly I will focus on how students learn in groups, and specifically in groups in a professional education program where PBL is used.

Situated learning as a learning theory tends to focus on practical training in workplaces, something which I have not observed. I will use it, however, as it contributes with a perspective on how to perceive knowledge and learning as situated. The perspective “emphasises that knowledge is constructed in practice, and that the context within which learning occurs is vital to the knowledge constructed” (Johnson 2004: 59). Jean Lave and Etienne Wenger (1991) developed the theoretical framework of situated learning through discussions of the role of a community of practice. Their main point is that learning is a process that can be understood through “legitimate peripheral participation” in a community, when newcomers learn from old-timers through practical training and participation. The newcomer, they explain, begins by doing not-so-central tasks and only becomes a full participant through a long apprenticeship training where s/he observes experienced practitioners (1991: 29ff).

Studies of professional education and learning within this sociocultural perspective of situated learning emphasize, among other things, the advantages of letting students practice different procedures in safe but authentic situations with, for example, medical simulators (Johnson 2004, 2010). Students also learn how to handle responsibility and uncertainties through working with supervisors in workplaces (Blåka 2006). But even though these studies show the significance of practical training to carry out the work role, I think that emphasis should also be placed on school-based training. In a professional education, such as the one studied here, students do not cease being “legitimate peripheral participants” just because they have left their practical training. I see their school-based discussions as part of their work to understand what the proper norms and behavior are within a larger community of practice. How do they talk about their practical training in wards? Do they talk about responsibility and uncertainty, if so, in which way? What can students learn together and from each other when discussing those experiences?

At work, midwives organize information about the patient and her partner, the baby's position, and the delivery's progress, in a specific way that facilitates what Åsa Mäkitalo in another context describes as "... a professional form of sharing expertise" (2012: 71). This way of organizing information occurs, for example, during shift changes when a midwife hands over her patients to another midwife, or when they insert information in medical journals. The information given, the "form of sharing expertise", reflects what practitioners believe they need to know in order to carry out their work in a professional manner:

So, while *knowing* is socially recognisable in action as part of a social practice, *learning* emerges in situations where gap-bridging, meaning making and coordination of actions and perspectives are necessary to be able to carry on with ongoing activities. (Mäkitalo 2012: 61, italics in original)

In my study I will discuss such learning as it takes place when students share experience and build knowledge about the proper way to be a midwife. Thus, the situatedness of my study concerns the situation of university-based group discussions within PBL.

PBL is a student-centered learning method, and is a special kind of situated learning. Students work together in collaborative groups which are often consistent over longer periods, and they meet frequently. The groups often work with case problems distributed by teachers; together the students formulate problems to investigate and frame collective learning goals. The teacher's role is to support the group discussion, not to lead it.

The method was first developed within medical training by Howard Barrows (1980) and later evolved into many variations (see, for example, Barrows 1986 and Ochoa & Robinson 2005). It is particularly common within medical training but also within education in the social and natural sciences. Three interconnected learning processes are said to go on among students using PBL, which brings about a complex learning situation. First, the students learn about the work process in collaborative group sessions, which briefly means that they proceed from formulating problems based on a case

problem to identifying usable concepts, research questions, and learning goals. Second, the groups are consistent over a longer time and the groups' work process should also advance, which means that their ability to formulate research problems and to work together so that everyone participates in the discussions and comprehends must be prioritized. Finally, the students should increase their knowledge, both together and individually (see, for example, Hammar Chiriac 2008). Overall, group dynamics is of importance in order for the method to work satisfactorily (Balasooriya, di Corpo & Hawkins 2010: 42).

Research about PBL has explored each of these different learning processes and the method as a whole. They have focused on questions about the benefits of PBL, how it can be developed as a teaching method, how students learn through PBL, as well as on its problems and limitations (see Balasooriya, di Corpo & Hawkins 2010, Bliuc et al. 2011, Hammar Chiriac 2008, Schmidt, Rotgans & Yew 2011, Ochoa & Robinson 2005).

Barrow's initial idea when developing the method was to let students practice their reasoning on authentic cases to better prepare them for working life. This is still brought forward as the main benefit of the model (Hung 2011: 531). The method has been criticized as not being an effective learning method, and one of the shortcomings of the model is that, because it builds upon collaborative work, severe problems may arise in dysfunctional groups. This criticism has been answered with the argument that the method is then not being used correctly, or that it only points to the need for developing the method further (Hung 2011: 541ff).

Negotiations and categorization work

My material from the midwifery education program is shaped by the pedagogical method applied there, taking advantage of the intense group discussions around case problems, usable concepts, research questions, and learning goals. I have focused on situations where the students, as future midwives, together discuss how to categorize situations and how to handle them as midwives. *Negotiation* is a useful concept for understanding the giving

and taking of arguments, interpretations, and stories of experiences. It is inspired by the work of sociologist Anselm Strauss (1978), who has brought attention to the *process* of negotiation, to its underlying *structures* as well as to the negotiation *context*. Hence, I want to explore in what ways the process of negotiations led to collective understandings of how to categorize and handle different situations and patients. As I will show, the students' negotiations sometimes lead to consensus but were also often open-ended. What the students negotiated was a professional approach and I will discuss the underlying "structure" of the professional norms involved. I also want to relate what is discussed to the educational context and the structure of the collaborative group sessions.

To capture the content of what the students negotiated about and what was included as relevant information about patients and the birthing process, I will use the concept *categorization work*, inspired by Mäkitalo's concept categorization practices (2012). However, by calling it work instead of practice I point out that the students struggled with negotiating how to perceive different kind of situations, i.e. they did work, but it was not as routinized as the practice term implies. Hence, the students had not learned the everyday practices of midwifery, and thus not what studies within practice theory focus upon (Reckwitz 2002). I will show that situations and patients are categorized as either normal or complicated cases. What that means is not given but must be substantiated on the basis of textbook knowledge and experience – the interpretation of which is done through negotiation.

The concept of a *normal birthing trajectory*, inspired by Strauss (1985) and Wiener et al. (1979), will be used to understand the norms of the category of a normal birth. Another useful concept is the one of *predictive marker*, inspired by Mesman's concept prognostic marker (2005). It will be used to analyze how the students negotiated how to recognize signs of potential deviations from the normal trajectory, and what is considered as "normal" patients and actions – as well as how to handle such deviations.

I think of the students' collaborative group sessions as both a collective learning and an individual learning situation. The collective aspect is relevant for two reasons; they all contribute by telling stories from their practical

training about what kind of situations they have encountered and may encounter when working. Together they negotiated matters that they needed to learn as future midwives. In this way, they can be said to together build what Mäkitalo calls a *body of knowledge*. She uses the concept to understand how persons working in an IT helpdesk team documented the cases they handled, from receiving queries and identifying problems, to the problems being solved. The cases were thus accessible to others and could be used by them when encountering a similar problem (2012: 66ff). In a similar way, I see the midwifery students' sharing of experience-based stories and discussions of cases as a way for them to build a body of knowledge of how to recognize the normal and the complicated and how to correctly handle different kinds of birthing trajectories. My specific focus is on the professional norms involved in this work.

Professional norms

The concept of norms is complex, and slightly differently defined in different disciplines. In a sociological definition, norm is separated from value but both are defined as “evaluative beliefs that synthesize affective and cognitive elements to orient people to the world in which they live” (Marini 2001: 2828). The distinction between the two concepts is described thus: “Whereas a value is a belief about the *desirability* of behavior, a norm is a belief about the *acceptability* of behavior” (Marini 2001: 2829, italics in original). But in the midwifery student education, and in my material, these were often inseparable. Therefore, an anthropological definition better suits my purpose of how to understand norm. Norm, by this anthropological definition is both the ideal and the standard way of doing something (Siegetsleitner 2006: 1750). In other words, it includes both the desired and the acceptable behavior.

As the students become midwives, they become part of a professional group where they are expected to adjust to prevailing norms. As noted in the introductory chapter of this thesis, “... a norm prescribes or expresses an

ideal pattern or standard of behavior in a given social group or social context to which conformity is expected” (Siegetsleitner 2006: 1750).

This understanding of norms points to the collective aspects of learning professional norms in midwifery. In studies of healthcare professions, questions have been raised about what it means to be a “good” practitioner (Halldorsdottir and Karlsdottir 2011) and how students can learn the virtues of the “good” professional role (Clouder 2003, Duncan, Cribb and Stephenson 2003, Lindberg 2009). Sigridur Halldorsdottir and Sigfridur Inga Karlsdottir (2011) have analyzed “the primacy of the good midwife” and what they call “core values”, that is, norms about how to be a professional midwife. The core values include how midwives should care for the whole family in the birthing situation, how they should empower birthing women as well as how they should continuously develop their professional and personal roles. The good and professional midwife is someone who at the same time holds a professional distance and shows a personal engagement. Even if personal variation between midwives is allowed, the professional norm seems to be that all midwives should act and be alike. This provides an important background to why the midwifery students spend so much time on negotiations about norms and to how they try to find common approaches to how midwives ought to act; the professional midwife is in a sense a standardized practitioner.

Peter Duncan et al. (2003) argue that norms about the “good healthcare practitioner” reflect values embedded with healthcare in a wider perspective. Hence, what the practitioner can do is interwoven with “medical virtues”, that is with ideas of using both technical medical knowledge and humanistic skills in the patient encounter. Studies by Clouder (2003) and Lindberg (2009) also explore the ideals that medical students encounter during their education. They show the importance of not only learning what to do but also how to do it the “proper” way in a community of practice.

Professional norms in these studies appear as idealized ways of being a good practitioner but also as explicit demands on how to perform the work role. Paul Haidet has problematized these demands; it is difficult work to uphold professional norms and patient-centeredness in practice. The

challenge, he argues, is to teach medical students how to support patients while delivering information that may change the patients' lives. Haidet points out that patient-centered care, which is what students find difficult to learn, expects the medical practitioner to both "think and feel", i.e. to not only conduct examinations or deliver information, but to offer support to patients while doing it (Haidet 2010: 644). The norms surrounding how to support different kind of situations and patients, both medically and emotionally, and the difficulties involved is something that I will discuss in relation to the midwifery students' negotiations about professional norms.

These studies have provided inspiration for my discussions about the ideal professional role advanced within midwifery education. However, as I see it, they only vaguely touch upon what also interests me here, i.e. norms about feelings and how they are learned within an education. For example, Lindberg writes that medical students are taught that they should be empathetic in their work role, but does not analyze what this means to the students in different kinds of situations.

Norms about feelings and emotions

The midwifery students talked about "a midwife's professional attitude" in different learning situations. It includes which kind of emotions they ought to express and feel, that is, norms. But they also talked about patient feelings in a normative way.

My main interest in this study is not to explore feelings in themselves but rather norms about feelings, as part of a professional role. However, a short discussion is needed about how I understand feelings and emotions, as it has a bearing upon the analysis. I use these concepts synonymously and thus aim to position myself with those who criticize that a firm distinction can be made between what a person experiences and what s/he expresses, and thus distance themselves from a mind/body dualism (Leavitt 1996, Sturdy 2003, Zembylas 2007).

In this work I neither study what emotions do (*cf.* Ahmed 2004) nor set out to explore specific emotions (*cf.* Fitness 2000, Wettergren 2010); instead

I try to combine an anthropological and a sociological approach towards emotions and norms about emotions. I derive my general perspective from anthropologist John Leavitt's understanding that what we experience as emotions involves "both cultural meaning and bodily feeling" (1996: 531). Hence, the experience includes both meaning and feeling that are learned through socialization (Leavitt 1996: 526). Leavitt proposes a rethinking of emotions or a "refeeling of emotions", giving as an example: "... to be anxious is to have a *feeling* associated with meaning" and thus, that meaning is a cultural understanding in terms of what is recognized as emotions and that how something is perceived is not necessarily universal (1996: 515). This perception of emotions is used in my analysis of how midwifery students spoke about emotions in relation to different practices and experiences within their training.

In Leavitt's approach towards emotion, there is also an aspect of collective experience, namely that there are culturally marked emotions (1996: 526ff), and that emotions are not only individual.

Affective or felt associations ... are collective as well as individual; they operate through common or similar experience among members of a group living in similar circumstances, through cultural stereotyping of experience, and through shared expectations, memories, and fantasies. (Leavitt 1996: 527)

Leavitt exemplifies the collective aspect of emotions through the example of Christmas and writes that it is "... accompanied by a stereotypical set of emotions" such as "joy and homeyness" (1996: 527). His point is not that everyone experiences these emotions, but rather that emotions in relation to Christmas are not randomly evoked. In the same vein, perceptions of childbirth are not random. As I will show, there was a collective approach towards childbirth included in how midwifery students and teachers talked about it, namely as a beautiful moment when a new life is brought to the world. How birth is perceived evokes feelings in accordance to the meaning, for example being moved to tears by the beautiful birth. In Leavitt's words, being moved to tears would be called a "stereotypical set of emotions", but I

prefer to call it norms about feelings. A stereotype gives a simplified picture of something while a norm, on the other hand, refers to the proper way of feeling. A norm could be both the presumed most common and the ideal.

However, Leavitt argues, while not everyone necessarily feels the expected emotions, they still are aware of them. For example, many people have strong feelings towards the “stereotypical set of emotions” associated with Christmas (1996: 527).

The same could be said about norms about feelings, something which will be discussed in Chapter 5, where I analyze how the midwifery students discussed their first experiences of childbirth. Hence, I will use a perspective on emotions as both subjective and collectively experienced, and see them as part of the professional role within a community of practice.

To understand such collective norms about feeling, I have turned to the work of sociologist Arlie Russell Hochschild (1979, [1983] 2012). She has analyzed emotions as part of job descriptions and as built into organizational structures, which she exemplifies with flight attendants learning how to be friendly and service-minded. Her starting point is that the individual, an organization, or a society has to manage and control emotions. A job description includes both knowledge and skills to carry out the work but also norms about appropriate emotions for the professional role. According to Hochschild, especially those working within caring jobs and service occupations are expected by the organization to handle their own, as well as the customers’, passengers’, or patients’ emotions. This is what she calls “emotion work”.

Emotion work differs from emotion ‘control’ or ‘suppression.’ The latter two terms suggest an effort merely to stifle or prevent feeling. ‘Emotion work’ refers more broadly to the act of evoking or shaping, as well as suppressing, feeling in oneself. (Hochschild 1979: 561)

Hochschild uses the term feeling rules to understand “the *extent*”, “the *direction*”, and “the *duration*” of how a person ought to experience feelings and express emotions in specific situations (1979: 564, italics in original).

Employers define the feeling rules about what to feel and how much to feel in different kind of situations. The feeling rules work as guidelines to how individuals should express emotions. A person tries to manage his/her emotions in accordance with feeling rules because of what Hochschild vaguely describes as “social guidelines”, stating that the feelings ought to be appropriate to the situation. They constantly remind a person how to feel, how to express emotions, and to what extent emotions are allowed (Hochschild 1979: 563f). Thus, the individual tries to manage his or her feelings according to the rules, which presupposes that the feeling rules are explicit, and that what a person feels inside and what he or she expresses can be separated and controlled by the person and by others through ways of upholding the rules (“rule reminders”).

Hochschild thus makes an analytical point in separating what a person feels inside, i.e. the feelings, and what s/he expresses outwards, that is, the emotions. A person engages in either surface acting, when the emotional expression does not correspond with what s/he feels, or deep acting, when he or she tries to change how s/she feels towards something and thus also the emotions expressed. Hochschild gives the example of a flight attendant who in an encounter with an angry passenger imagined that the man in question might have experienced something traumatic and that is why he behaved in that way ([1983] 2012: 25). Evoking feelings of empathy in this way is what Hochschild calls deep acting. To put on a smile but feel irritated by the man’s behavior would be surface acting.

Hochschild’s analyses of emotion work, feeling rules, and rule reminders have been further used and developed by others (e.g. Bolton 2000, Fineman 2005, Hunter 2001, Sturdy 2003, Thoits 1989, 1996). They have shown that controlling one’s emotions is central to caring jobs such as nursing and midwifery. A competent practitioner is able to carry out the work without becoming too emotionally involved with the patients, to uphold a professional approach and to support patients (see Bolton 2000; Fineman 2005; Hunter 2001; James 1992; Smith 1998). In her study of gynecology nurses, Sharon C. Bolton sees their work as “maintaining the professional face” which means that they learn to “mask” their own feelings in order to be able to emotionally

support the patients (2000: 584). Helen T. Allan (2001) has studied nurses at a fertility unit and found that they managed their emotions through keeping an emotional distance to patients, something that she calls “non-caring”. She argues that the nurses, through emotional distance, managed to care for the patients who carried with them heavy grief about infertility (2001: 18). In a recent study, Petra Jonvallen (2010) similarly writes that midwives express a “detached concern” for the patients to manage their daily work, which resembles what Allan describes as non-caring.

I will use Hochschild’s theoretical perspective to understand that there are often strong expectations about how to feel in a professional role. However, the studies mentioned do not problematize the rules or norms. On the contrary, they focus on how people control and evoke feelings in accordance with norms and rules and on the problems that might arise if how they feel and how they are supposed to feel do not correspond. However, I distance myself, as already mentioned, from the idea that there might be a clear division between what a person feels and what s/he expresses as an emotion. Thus, I find it problematic and difficult to claim that the students do deep acting in one situation and surface acting in another.

In addition, I see the norms of proper feelings as more flexible and negotiable than is the case in many studies based on Hochschild’s work. I will, therefore, use the concept *feeling norms* instead of feeling rules, as it, in my view, is less constraining and also links more clearly to a social community. I wish to elucidate the negotiations and open-endedness around what feelings are appropriate within a community, whereas the concept of a rule seems to give a more definitive definition of what should be felt and expressed. Thus, I want to open up for different and even contradictory interpretations and also want to elucidate the idealizing aspect of a norm, something which is not well covered by the concept of a rule. In addition, the concept allows the inclusion of both “the usual way” and “the ideal way” of how feelings are experienced and expressed. In what follows, I hope to show that feeling norms in professions and education are complex, idealizing, and culturally understood. Hence, I expect the feeling norms concept to capture the midwifery students’ perception of what being a midwife meant to them and how they negotiated

about it. I will also discuss the students' negotiations and their narratives of experiences as a form of "rule-reminders" about the proper feelings.

I will also use Hochschild's idea that these expectations are not only about suppressing one's emotions, something that has been emphasized in previous studies of care work, but also about evoking and shaping emotions in a desired way. In midwifery, part of one's work is about making others feel safe, happy, and content, something which puts a demand on midwives to act in not only a controlled but a positive way.

To sum up: This study is based on two central perspectives; one concerns situated learning, and the other is oriented towards norms of birth and emotions in professional work. I will analyze how students together negotiate, form, and discuss what I will see as a "body of knowledge" about the proper way of emotionally approaching birth and patients. Concepts such as the normal birthing trajectory, predictive markers and categorization work are used to understand certain normative – but negotiable – views of how births should be and patients and midwives should act in order for a delivery to become or be considered normal. Another central concept used to elucidate how students try to comprehend their future role as midwives and its appropriate attitudes and behavior is "feeling norms". I will now turn to how these various perspectives and concepts have influenced the methods and analytical work of this study.

3. Material and methods

In this chapter, I will present my material and the people in the study, and reflect upon methodological considerations about how to study norms about birth and professional feelings. I will also discuss how my “project design” came about, and changed along the way. I aim at presenting this without making the choices seem too intentional or the process too linear, which it never is, except possibly when writing the story afterwards, making decisions look more deliberate than they may have been. As George E. Marcus points out, it lies within ethnography as a method to be open to what might happen in the field and to continuously work on the design (Marcus & Okely 2007: 356).

The thesis builds upon ethnographic field work carried out over the course of a year in a midwifery education program in Sweden. With the help of detailed field notes and transcribed audio files, I have analyzed how the students discussed aspects of feelings and norms in midwifery practice. To acquaint myself with the field, I also observed midwives in a delivery ward for a few days, and analyzed a television documentary about Swedish midwives. The documentary called *Barnmorskorna* (“The Midwives”) was broadcast in eight episodes in 2008.⁹ Together with preparatory interviews with midwifery teachers, this material contributed to my initial interest in how normal birth is understood in midwifery practice and in how students learned the “right” feelings in different kinds of birthing situations.

⁹ Material from the documentary is not included in the thesis. There is, however, a published version of Chapter 7 about the good and normal pain in midwifery where this material is part of the analysis (Gleisner 2013). Chapter 7 is a rewritten version of that piece, where material from the documentary has been replaced by material from my fieldwork among midwifery students. There has also been additional work on the analysis.

Finding norms through ethnographic research

Different methodological approaches generate different types of data. Ethnography as a method can be defined as “the analysis of the culture of a community or other distinctive social unit, grasped through the method of participant observation” and “the written account of such a study” (Winthrop 1991: 98). Thus, ethnography is both the method applied and the product of such study. But

... ethnography isn't *just* about shared knowledge; rather, it's about the *practices of everyday life*, the way those practices are built out of shared knowledge, *plus* all the other things that are relevant to the moment. (Agar 1996: 9, italics in original)

As Michael Agar writes, through ethnographic work it is possible to study “*practices of everyday life*”, i.e. what people do and how they do it. As a method, it opens up the possibility to find analytically interesting aspects about what people do, before even knowing the significance of it. Agar also presents an urgent question that needs to be addressed, “what is the broader goal with ethnography?” (1996: 127). This question needs to be answered in all work that claims to be ethnographic in its character.

The main benefit of ethnographic work and of being a participant observer is the possibility to come near the informants' perspective, just as Bronislaw Malinowski once wrote when he established ethnographic work as a research method within anthropology ([1922] 2007: 47). Through ethnographic work, the aim is also to gain an overall understanding of the context in which something is said and done. Thus, ethnographic work is a well-suited method for setting out to study norms. The fact that norms are not easy to grasp in situations like interviews is illustrated by a response I received when I asked one of the midwifery teachers to define normal birth, and she had trouble describing what normal birth is (the quote introduces Chapter 1). Instead, through many instances of listening to students learning and discussing births and patients, I could begin to formulate what was considered normal birth and norms about how to approach the subject as a

midwife. In other words, this is an ethnographic study because I have sought to understand a perspective on normal birth as midwifery students discuss and learn about it in their education. However, there is a possibility of me having missed some relevant aspects and misinterpreted other.

Some norms about birth were easy to capture, e.g. that normal birth takes place in a hospital setting, that the woman is expected to bring someone with her when she comes to the delivery ward, and that a midwife helps her through labor. Such norms about normal birth are analyzed in Chapter 4. Finding other norms, about how a midwife should emotionally approach different situations and which feelings are “right” in different situations, and thus add up to norms about professional feelings, were harder to detect but facilitated by the use of an ethnographic method. I analyze these norms about professional feelings in Chapter 5 and Chapter 8.

When I entered the field, I did not know that normative understandings would be the core of my analysis. However, I was inspired by Arlie Russell Hochschild’s ([1983] 2012) theoretical perspective on emotions and set out to understand how midwifery students learn to handle emotions, both their own and those of patients. In Hochschild’s best-known example, that of how flight-attendants learn to manage emotions at work, she shows how they are presented with the feeling rules established by the organization. The flight attendants know what is expected of them and come up with strategies how to perform the role of the smiling, helpful person, and they know that their calm and smiling faces should be reassuring to passengers who fear flying or those who fear delays (Hochschild [1983] 2012). Hochschild points out something very important: “For the flight attendant, the smiles are a *part of work...*” (Hochschild ([1983] 2012: 8, italics in original). Feelings and emotions are part of work requirements. With this in mind, I entered the field, being attentive to feelings and emotions. But, in contrast to Hochschild’s study about flight attendants, the midwifery students had neither specific guidelines nor rules about how to handle feelings and emotions. I have thus studied their negotiations of the “right” feelings (both their own and those of patients) in different situations and analyzed the process in which their norms about the professional feelings of a midwife crystallized.

Field work at the midwifery education program

I will now give a fairly detailed account of my research process in midwifery education. Giving the readers a possibility to grasp what material the study is based on will aid in assessing credibility of the analysis. I want to establish what Karen Golden-Biddle & Karen Locke (1993) discuss as the authenticity of a study, i.e. make it plausible that I was there, in the field among midwifery students and striving towards understanding how they perceived norms in midwifery.

The process of trying to enter the field and receive the participants' informed consent can be a difficult and tedious one (Agar 1996: 79). However, I experienced gaining access as relatively easy. My initial plan was to observe midwifery students both during the university-based part of their education and during their practical training in wards. To gain access to the field, I contacted one of the midwives working in a midwifery education program, and she was instantly interested in my research. Following midwifery students throughout their education was so different from the studies usually conducted within midwifery research that it became an advantage for me.

Based on the teacher's advice, I contacted the director of the program, and received a written approval to conduct the research at the midwifery education program. I provided information to all people involved before beginning my field work, telling them about the study, that an ethical committee had reviewed it, that they could contact me anytime if they had any questions about their participation, and that I would protect their identities (*cf.* "Code of Ethics", *American Anthropological Association*, [1998] 2007).

Starting with interviews with the teachers facilitated getting in contact with those I really wanted to observe, namely the students (for different techniques to access the field see Agar 1996: 79ff). All in all, four teachers worked at the midwifery education program. Two of them still worked part time as midwives (one with ultrasounds and the other with parental education). The two other worked full time at the university. I interviewed

only three of them as the fourth teacher only began her work after I had started following the students around.

The first midwifery teacher I approached became a gatekeeper who opened many doors, both to the midwifery education program and to the delivery ward. On the other hand, she also closed the possibility of me observing midwifery students during their practical training. As she explained it, midwives, both teachers and those working in the ward, were keen on keeping the number of people engaged with each patient as low as possible. Hence, my initial plan had to be changed, since I could only observe the students during the university-based part of their education.

The midwifery education program covers three semesters. I chose to observe two different groups of students and thus to observe students during all three semesters of study, but within one year of field work. During my field work, a class consisted of fourteen students. Each class was divided into two groups of seven students each.¹⁰ The students never changed groups, but stayed in the same group constellation during collaborative group sessions, clinical skills practice, and some of the seminars. I chose to observe only one of the groups in each class to avoid uncertainty about where I would be and when.

The midwifery students were all women. Most of them were in their late twenties or thirties, and the vast majority of them were ethnic Swedes. They lived in the city where the midwifery education program was situated, or nearby. As midwifery students, they shared previous experiences of working as nurses, as it was part of the admission requirements.

My field work began in the fall semester, when I observed second-semester students. I continued to observe this class in their third and final semester during the following spring term, when I also observed a group of first-semester students. This somewhat backwards way of observing the students' progression during their education nevertheless gave me some valuable insights. In contrast to the midwifery students, I started by hearing

¹⁰ One of the second-semester students went on parental leave and was away most of that semester as well as the third semester.

about complicated pregnancies and births, which was part of the second-semester courses. Hearing the second-semester students talk about everything that could go wrong made me more observant of how normal pregnancy and birth were understood.

Observing two classes at the same time also had its downsides. During the spring semester, I sometimes had to prioritize between the groups. Once I chose to observe the first-semester students instead of the third-semester students, as they had their first collaborative group session after their first practice at clinical sites. One of the midwifery teachers recommended that I should participate in that session because she thought it would be interesting to me, which it was (I write about the students' first experiences of practical training in Chapter 4). Another time I chose to observe the third-semester students because they were in their final days of the program. I expected them to talk about their overall experiences of going through the education and what they would be doing next, which they also did.

At an early stage, I decided to focus on how the students discussed midwives' work with pregnant and birthing women and how that was understood. Issues of pregnancy and birth constitute midwives' main work area and also take up most courses within the midwifery education.

As indicated above, I did not follow the students for the five-week periods of practical training in clinical sites that they went on twice every semester. However, I listened to them narrating their experiences to the other students. Thus, I got an insight into how they talked about their clinical practice and also observed them when they did some practical training during the university-based part of the education, so-called clinical skills practice. During these sessions they practiced sewing ruptures in and around the vagina on cow tongues, estimating placentas and the cutting of navel strings, as well as documentation of labor and normal and complicated deliveries on birthing simulators.¹¹

¹¹ I have not included an analysis of these training sessions in the thesis; they are only mentioned in passing. However, I have given a presentation about it in a conference organized by *The Swedish Research Council (Vetenskapsrådet)* in November 2012.

To sum up, I attended lectures, seminars, course reflection hours, collaborative group sessions, clinical skills practice, and held informal conversations with the students during free periods, lunch and coffee breaks. Through field work and through participating in all kinds of learning situations, as well as breaks, I got some context of why students discussed a topic and what was said before and after the group sessions.

My participation during scheduled hours is presented in Table 1 below. Including coffee and lunch breaks and free periods, I spend approximately 200 hours with midwifery students. The table shows the number of different learning situations I participated in, but not how many hours I spent observing lectures or seminars. A lecture was two hours, a seminar varied between two to four hours, and a collaborative group session was three hours.

Table 1. Learning situations observed during field work

	First-semester students	Second-semester students	Third-semester students	In total
Lectures	5	6	2	12
Seminars	1	1	1	3
Clinical skills practice	3	1	0	4
Collaborative group sessions	4	6	4	14
Course reflection hours ¹²	1	2	1	4

As shown in Table 1, above, I observed and audio recorded many collaborative group sessions. Problem-based learning (PBL) structured the sessions and the students' discussions in a way that was favorable for me. The main idea of PBL is that students discuss and go through several processes of learning (Hammar Chiriatic 2008). The midwifery students often had a case problem to discuss during collaborative group sessions. Their discussions always followed a pattern that can be traced back to the teaching method,

¹² In Swedish: "kursdialog". Students and teachers met and spoke about whatever needed to be discussed concerning courses, assignments, or exams.

problem-based learning. Overall, the students' assignment included formulating the patient's experiences and to discuss how the patient's problems might affect her and the baby, and decide on how they as midwives could help and support the patient. This approach was not typical to this specific topic but rather something applied in many collaborative group sessions and something that structured the students' discussions. The students' group discussions centered on how to recognize different kinds of situations and how they should approach them properly.

In group sessions where PBL is applied, the group dynamics is of great importance; it is also important that everyone participates. At the end of some sessions, the teacher encouraged the students to reflect upon their individual participation and how they estimated their joint work in the group. Exercises where students reflect upon their work, noting whether everyone participates, and whether someone speaks more than others, aim at both acknowledging inequalities among students and decreasing them (Balasooriya, Di Corpo & Hawkins 2010: 40). Despite the reflection exercises, both the students and I perceived that some persons spoke more than others. This is also visible in my thesis but I have tried to include everyone and not let only a few of the students speak for them all.

At the same time as the structure of PBL facilitates negotiations around the topic to be studied, the group dynamic processes also constrains and controls what participants in the group might express and the stories they share. For example, the experience-based stories told were primarily examples of the topic to be discussed during that session. There was limited space to talk about experiences, or issues, beyond the session themes.

My usual procedure during all sessions was to state clearly before they started that I would record the session. I did not turn off the recording until the session ended and the group had gathered things together and was prepared to leave.

While Chapter 5 mainly builds upon material from the group interview I conducted with students, material from collaborative group sessions form the core of my empirical chapters 4, 6, 7 and 8. I include material from several sessions in each chapter to show that certain topics were important to the

students during the whole educational program. There is one exception. Chapter 8 is mostly based on the discussions from one session only. The theme of this session was special as it was about handling birthing situations in which babies are stillborn. However, I will show that the students' discussion of the proper feelings in such situations was similar to their overall negotiations of professional feeling norms. I have included excerpts from ten of the fourteen collaborative group sessions in the thesis, however, the analysis builds upon material from all sessions as well as from interviews and informal discussions.

In the collaborative group sessions, as well as in other learning situations, narratives were often given about the theme or problem discussed. Students told stories about what they had experienced during their practical training, and teachers told stories to illustrate how to recognize and handle different kind of situations in the delivery room, for example if the birthing pain is too intense for the woman to handle (this is elaborated upon in Chapter 7).

The stories often included emotions and evoked feelings. Experience-based stories appeared to fulfill several different purposes: to enrich the teaching, to share knowledge, to bridge the distance between theoretical and practical training, and to highlight a specific situation. Furthermore, the stories included how students experienced the situation (e.g. joyful, funny, scary, instructive, confusing, unfair, or weird). Thus, how the students told the stories and discussed them elucidated how they related emotions to different situations and patients, as well as feeling norms within the profession and in the education. Experience-based stories are included in all empirical chapters. There I show how students talked about patients as bodies, about patients from a social and medical viewpoint, and about patients as emotional.

Based on this presentation of my field work, two questions emerge. If I spent most of the time listening to students talking with each other, how do I define participant observation and in which way can I say that I have done ethnographic work? To be a participant observer is to "enter the world of the people you're working with rather than bringing them into your world" (Agar 1996: 9). However, being a participant observer is a complex role. Tom Boellstorff describes the complexity of being a participant observer:

The term ‘participant observation’ is intentionally oxymoronic; you cannot fully participate and fully observe at the same time, but it is in this paradox that ethnographers conduct their best work. (Boellstorff 2008: 71)

Boellstorff writes that this complex role of being a participant observer means that one has a “critical engagement” with those one studies (2008: 71). One is part of the social situation but not as somebody in the group. Boel Berner gives a description of being a participant observer in an educational setting, which can be seen as illustrating the complexity that Boellstorff has noted. As a participant observer in an education, the researcher is a participant in terms of participating in social interactions, but an observer in relation to what is taught and learned in the program (Berner 2005: 119). My role as a participant observer can be described in a similar way. I interacted with students and teachers but I did not study midwifery. I listened quietly in most teaching situations and only spoke when someone addressed me. But I was still part of the social interaction, as the student included me by also looking at me while they were talking, and I laughed at jokes (when I understood the jokes, or pretended to understand).

During the hours in between classes I was both an observer and a (much more active) participant in social interactions. My taking part in the midwifery students’ conversations then brought me closer to them and also gave an additional understanding of how they spoke about emotions and about norms of what to feel and what not to feel. In other words, what the students said and how they said it differed between situations. There were more jokes, more laughter, and wider areas of subjects discussed in the hours between classes than at the collaborative group sessions or lectures. Subjects discussed during lectures were often followed up during breaks, but then the students gave descriptions that were more detailed. For example, they thoroughly described and compared how it felt to learn how to perform vaginal exams. Joining the students during breaks also constituted the situations where my role as a participant observer became prominent, as these were social

situations where I felt (almost) like one of the group. But of course, I could not share any stories of my own.

My field work among students has little in common with the classical idea of what field work is, as developed and described by Bronislaw Malinowski ([1922] 2007). Even so, Malinowski's descriptions of proper anthropological field work served as inspiration for what might be gained through ethnography as a method because "... the field work style he validated was less a matter of concrete prescription than of placing oneself in a situation where one might have a certain type of experience" (Stocking 1992: 58). Hence, through observing students and listening to how they discussed how to encounter and handle a situation I learned things I would not have learned with other methods, such as interviews or documentary analysis. Furthermore, through observing other learning situations as well, and joining the students during coffee and lunch breaks I got an insight into the context in which things were said during the group sessions and came near the student perspective. Besides, the classic type of field work where the anthropologist travels far away to an exotic place, and isolates him- or herself to live with strangers until the exotic becomes familiar, was not even carried out by Malinowski himself (Marcus & Okely 2007: 357ff).

Interviewing teachers and students

I also conducted interviews with midwifery teachers and one group interview with four second-semester students. Furthermore, I continuously conducted informal interviews, i.e. I not only participated in informal conversations but also asked questions. I decided against doing individual interviews with students, as my focus was on how students collectively discussed and negotiated attitudes towards patients and the birthing situation.

The formal interviews had different aims. I conducted introductory interviews with three of the midwifery teachers and an additional interview with one of them. My questions related to general issues about the midwifery education program and how the teachers viewed the students' change of profession from nurse to midwife. The additional interview concerned the

teacher's view on experience-based stories in teaching situations. I was curious to know the teacher's opinions of the stories told and what signified a "good" educational story.

The purpose of the group interview was to hear more about how the students perceived their future profession and the patients they would work with (*cf.* Kvale & Brinkmann 2009: 121). I therefore asked them about a "significant moment" in their lives as midwifery students, in this case the first childbirth they had attended. I thought that they would all remember this experience and have strong feelings about it. According to Viveka Adelswärd (1996), the narrative of a significant moment may highlight culturally specific aspects of a situation and also will give details about time, place, and individual reactions. How the students narrated this experience and what they included in their stories would, I expected, help me understand important dimensions of how a future midwife was expected to feel about her professional role.

During the group interview I also asked about how they learned sensory knowledge, that is, to feel with their hands, like doing abdominal examinations to estimate the baby's position, and vaginal exams. Other questions were not as specific about learning. I was curious about their decision to become midwives and in which area of midwifery they wanted to work.

By conducting a group interview with four students, I got the opportunity to steer the conversation more than was possible during informal conversations over coffee or during the collaborative group sessions where I did not actively participate in the conversation. But I did not need to continuously ask questions to get the students to talk. Although they did not all belong to the same group – they were in the same class but equally divided between the two groups – they were used to talking about their experiences in front of others, reflect upon them, ask each other questions, emphasize what is seen as important, and also work to have everyone participates in the conversation. This meant that I did not need to make sure that everyone participated in the conversation. But in contrast to the situation in

collaborative group sessions, I could follow up with questions, and I had my own agenda of what I wanted the students to discuss.¹³

Observation in the delivery ward

I carried out two short periods of observation in a delivery ward. One of the midwifery teachers helped me to get in contact with the head midwife at the ward and they invited me to a staff meeting to do a presentation. I stayed for five workdays altogether to get an idea of what is involved in a midwife's work in the ward. Three different midwives volunteered to let me observe them. Before we met any patients, I explained about my project, my research method, and answered the midwives' questions. The midwives also read the letters of information that I handed out to patients. No patient, whom I asked for permission to be present in the delivery room whenever the midwife was there for exams or check-ups, had any objections to my presence nor did they have any questions.

My first field work in a delivery ward was conducted in June, before I began the field work at the midwifery education program. The second one was done in May-June the year after, that is, at a time when I was about to complete the field work among the students. I carried out the observations at a university hospital where there were often students (midwifery students and medical students) present in the delivery ward; this meant that the midwives were used to having people following them around.

Seeing a delivery ward provided some important context and helped me formulate questions for my material. In the thesis, material from the delivery ward is used to introduce a subject, as in Chapter 5 where I describe my own experience of attending my first childbirth. Material is also used to provide context, as in Chapter 7, where I describe how a midwife in the ward reasoned about whether the labor pain a woman experienced was good and normal, or not.

¹³ I did not conduct a group interview with first-semester students because they spoke of these matters during group sessions.

Being a researcher in the field

Most of the people I met during my field work in the midwifery education program and in the delivery ward were women, with the exception of expectant fathers and one or two male obstetricians and anesthesiologists. The persons spoken about in the midwifery education program were also mainly women. Expectant fathers or partners were included in conversations and in the course literature, but held a secondary position to that of the women. Women's sexual and reproductive health, pregnant women, women in birthing, women's aftercare, and women facing menopause were the patients that midwifery students read about, studied, and learned to encounter within their coming profession.

Being a PhD student and a woman in my late twenties meant that I could be seen as either belonging to the teachers' group or the student group. In teaching situations, I was aware of this double impression and decided to always stay near the students to maintain their trust. I also consistently chose to have lunch and coffee with the students even though the teachers occasionally invited me to join them.

I was several times asked if I had any children, both in the education program and in the ward. At that time, I was not a mother. This probably made it easier for me to ask all the naïve questions of an anthropologist in field. But my later experiences of pregnancy, miscarriage, and childbirth may have affected how I have analyzed the material.

Conducting an ethnographic study in a midwifery education program meant that I left one university site for another. The similarity does not end there, and this is something that raises several methodological questions. Not only was I in a Swedish university environment where I was familiar with many cultural understandings, but I was also one woman among other women, of about the same age and social background as those I studied. I was also rather indistinguishable from my informants when it came to appearance. Being "invisible" probably made it easier for me to gain access to the educational field and move around in it. I was equally visible/invisible in the delivery ward. The delivery ward was an environment unfamiliar to me, but I

probably shared cultural concepts with most people working there. I always presented myself as a PhD student in social science, but I was nevertheless several times mistaken for being a midwifery student. The fact that my role as an outsider thus was not visible at first sight raises some ethical questions, such as the importance of always being explicit about one's role as a researcher.

One of the benefits of ethnographic field work lies in the prolonged time in the field, which facilitates the creation of trust between the researcher and the informants (Creswell & Miller 2000: 127ff). The more time I spent with the students, the more I felt that my position as an outsider diminished, and that my presence in the field became more or less taken for granted. That I had so much in common with the students of course contributed to this. At the end of my field work, both teachers and third-semester students joked about me being the only one having gone through a midwifery education without becoming a midwife. The students were curious about whether I was tempted to change careers and become a midwife myself (which I did not intend to do).

I struggled with problems both during my field work and after of how to do and write ethnographic field work within my own society. I have tried to define the culture the students shared, as both part of and separated from the culture *we* shared.

The midwifery students shared what I call a "midwifery sense of humor". This included jokes that referred to sexual behavior, sexually transmitted diseases, or medical treatments. That midwifery students joked about these topics was not surprising, but to do so without feeling embarrassed was not easy for me. When I first heard such jokes, as I observed the second-semester students, I was a bit surprised. A few times I almost blushed, and sometimes I did not even get the joke as it was based on knowledge and understanding among the students which I did not share (i.e. a problem of *indexicality*, see Agar 1996: 58). However, the more time I spent with the students, the more I got used to their jargon.

When I started observing the first-semester students during the second term of my field work, I knew about things that they had not yet learned. I had also gotten used to the jargon among the second-semester students. When

one of the first-semester students once made a joke about multiple orgasms, it was received with a little giggling from the others while avoiding eye contact. The teacher and I seemed to be the only ones not embarrassed. However, I was ignorant about some basic knowledge, such as about with which hand one performs vaginal exams (with the left hand if one is right-handed and vice versa). Mistakes like that reminded me of the researcher's complicated role in ethnographic work – describing the world as the informants see it, but lacking knowledge and skills, which means missing out on some things during observation.

I felt both happiness and sorrow during the course of my field work. It was not possible to detach myself entirely from what happened in the field (see Harding & Pribram 2004 and Zembylas 2007 for a discussion about being empathetic to the field). Stina Bergman Blix calls this being an emotional participant (2010: 61). In situations when I experienced intense feelings, I tried to keep my focus on those I observed and how they reacted to the situation or theme discussed. This was similar to how Bergman Blix described how she struggled with doing emotions as a professional researcher and not becoming too personally affected when she studied how stage actors worked with emotions and when she participated in their exercises (2010: 62ff).

Especially one collaborative group session with third-semester students seemed to affect everyone around the table very much, including myself. The topic discussed was women giving birth to stillborn children, which I write about in Chapter 8. How to support parents who have lost a child was not only a difficult subject in itself to discuss; some of the students also carried difficult personal experiences with them that were brought up in the conversation.

From material to text

In this section, I will describe how I transformed my field work into text based upon my observations and transcribed audio files. The aim is to discuss the choices I made along the way. In relation to what Karen Golden-Biddle and

Karen Locke (1993) discuss in terms of plausibility, I describe the analytical steps and conclusions presented as a text.

Approaching the material: from coding to presentation

Conducting field work at a midwifery education program implementing problem-based learning as teaching method included spending many hours of listening to midwifery students during collaborative group sessions. During these sessions, I joined the students around the table, but did not interrupt the conversations. I audio-recorded them and took field notes as a complement to the recordings, which illustrated how the students mapped out the problem on the whiteboard, and occasionally illustrated their body language.

During lunches and coffee breaks when I observed students and also when patients were present in the delivery ward it felt out of place to write field notes. I tried to memorize the interactions and the subjects discussed and wrote them down as soon as possible. In the delivery room I focused on observing what occurred in the room and on how the midwife spoke with the patient, her partner, and the assistant nurse. I wrote down field notes when we had left the room.

These notes should not be seen as raw data (Boellstorff 2008: 85). My analyzing process started in the field. The writing of field notes is not only a matter of recording observations. It is also about interpretations and descriptions. Spontaneous reflections on, for example, how the students spoke about methods of handling patient feelings were associated with other similar situations and to theoretical reflections about how Hochschild describes emotion work.

I transcribed almost all of the recordings from the collaborative group sessions. Not all material is interesting to include in this thesis, however. For example, I have left out purely “technical discussions” or “medical discussions”, which could include what a CTG graph looks like under different medical conditions, or between which vertebrae an epidural is to be injected.

In the transcription technique used, I emphasized accentuations in speech, pauses, cut-off words or sentences, drawn-out words, if something

was uttered with laughter in the voice or with an imitative tone, and also hemming and hawing. I was inspired by some of the techniques used in communication analysis (Linell 1994); a technique I used because I was afraid that if I left out occasional accentuations or because something was said laughingly, I would forget if something seemed to be said ironically, in frustration, or in anger. I think that it is difficult to separate what a person says from how she or he says it, and these nuances would be important for my later analytical work. The detailed transcription did help both in the coding process and the analysis because it made the transcribed text more vivid as I read it over and over again.

Besides marking words or expressions in the transcriptions, I also added material from my field notes, especially material that related to my reflections on emotions in the room. Thus, I included what Michalinos Zembylas calls “nondiscursive practices” (2007: 64), such as how the students used their hands to illustrate performing a vaginal exam. I also tried to describe the context in which something was said or done. Haris Agic writes about *emotional notes*, that is, emotional memories that stay with you: “What sets emotional notes apart from the mental ones is that they are not only easy to remember – it turns out they might be rather hard to forget” (2012: 105). Thus, I aspired to interpret the feelings I observed as well as the feelings I experienced myself, in the field notes.

However, I have made excerpts from the transcriptions more readable when presented in the thesis, which means that I have not included hemming and hawing or repetition of words. I have also tried to correct some of the grammatically incorrect sentences, but without losing the sense of the students talking (Boellstorff 2008: 85). As I conducted my study in a Swedish context where everyone spoke Swedish, I have translated quotes into English. When presenting excerpts in the thesis, I have sometimes added some explanatory text. For example when something was said in a sarcastic voice or in laughter, it seems important to note this, as it would otherwise not be understood by the reader.

It is important to protect the students’ anonymity. I have chosen not to name the university or the cities where the student did their practical training.

Nor have I given information about which year the students in this study attended the midwifery education program. I have given fictive names to all midwifery students and working midwives mentioned in the study. In the session about stillbirth one of the students told the group that she recently miscarried. In the chapter where that story is presented, I have given this particular student an additional name to protect her identity. Teachers are just called midwifery teachers.

Applying sensitizing concepts and themes to analyze norms and emotions

“Theory, writing and methodology are inseparable practices” (Zembylas 2007: 68). During my field work, I was open to what I might find, however I knew that my thesis would be about learning and emotions. Thus, I brought what Glenn A. Bowen (2006) calls *sensitizing concepts* with me into the field (e.g. emotions, learning, body, technology) that pointed to aspects that I was to be especially attentive to during my field work. They also included theoretical concepts, like emotion work (Hochschild [1983] 2012). Sensitizing concepts are used to “draw attention to important features of social interaction and provide guidelines for research in specific settings” (Bowen 2006: 3). Thus, they provide a way of navigating in the field. New sensitizing concepts were added (and some disappeared) along the way, to include more dimensions of, for example, how to account for how students spoke about norms about normal birth.

I used my sensitizing concepts to identify themes from the data and to find preliminary analytical ideas of what kind of feelings were expressed by and among the students. In the coding process, I approached field notes and transcriptions in a similar way. The first step was to divide the text into different sections, depending on which subject was discussed. Thereafter I proceeded with coding based on my sensitizing concepts. Initially, I spontaneously marked sections and wrote key words/code words/concepts in the margin. The more material I processed by coding, the more established the key words became. I thereafter looked for and developed themes to, for example, analyze the perception of pain in childbirth.

Based on my theoretical framework, I thereafter worked themes and preliminary analytical ideas into chapter ideas. Examples from different situations in the material were used to illustrate different aspects about the theme. Thereafter followed the difficult process of not only figuring out which points I wanted to make in each chapter, but also how the individual chapters would contribute to the thesis as a whole. Together with my theoretical framework and analytical tools, I aimed to show how normal birth as a category became more and more complex in student discussions and how students' negotiations of norms about normal birth and professional feeling norms were part of their training to become midwives.

In all chapters, I have aspired to give rich descriptions of the situation in which something was discussed and who participated in the discussion (*cf.* Geertz 1973).

This thesis is about negotiations of normal birth. Feelings are present in all parts of my work, in observation, coding, analysis, and writing. My field notes are full of reflections about emotions, both my own feelings and the feelings of the students. Thus, feelings influenced how I observed and interpreted the situation. Leavitt writes:

... that we do not know what someone else is feeling, is true only in the same sense that we do not know absolutely what someone else means when he or she says something. (Leavitt 1996: 529)

For the researcher to explicitly use his/her own feelings when analyzing the material is one way of approaching feelings in the field (Zembylas 2007: 66). I write about my own feelings to some degree. I begin Chapter 5 with depicting how I experienced the first childbirth I attended, with the aim of acknowledging that different feeling norms in birthing situations applied to both the midwives and myself. In Chapter 8, my feelings are included in the analysis to elucidate the provocative approach that death in childbirth is normal and how the students negotiated death.

Reflections about representing midwifery students learning norms

Some questions still remain: What can I say from the material I have, what claims can I make? I will return to the question of representation and generalization in the final chapter of this thesis but will also give some reflections here.

I have mentioned two of Golden-Biddle and Locke's (1993) concepts connected to convincing through ethnographic text, *authenticity* and *plausibility*. Authenticity is about convincing the reader that the researcher was there, among the informants, and caught their perspective on the world they live in. But it is also about situating oneself as a researcher. I have tried to do this by describing my interactions with midwifery students and midwives. An important point that I made was how I blended in because of my appearance. Another important point was my reflections on how my personal experiences – and the lack of them – may have affected the study.

Plausibility is about showing how the conclusions are drawn through analytical steps and considerations that make the conclusions “make sense”. This is something that I have strived for in several ways. It includes elucidating my methodological considerations, but also making clear the contribution of this thesis as well as the uniqueness of this study. I will return to these questions in the final chapter.

Golden-Biddle and Locke also use a third concept in their discussion about how to write convincing ethnographic texts – that of *criticality*, which refers to the presentation of the text. It should aim at getting the reader to reflect upon his/her own taken-for-granted perceptions and analyses. My aim in the following chapters is to show some not-so-obvious interpretations of how feeling norms are part of professional training and how the normal birth is negotiated as a culturally relevant and negotiated category.

4. Norms about the normal birth

It was a Monday morning in early February and my first field day with first-semester students. I had met them once before, when I introduced my study and myself. I chatted with some of the students in the corridor, then everyone entered the lecture room and we took our seats. The teacher was already there to hold the first introductory lecture in the course. The first picture in her PowerPoint presentation was a side-view photograph of a pregnant body, but it only showed the woman's big belly. A man held his hands on the belly and kissed it. The course's name "Normal childbirth" was also shown in the picture. I felt perplexed by the combination of the course title and the photograph, which said that what this image depicted was "the normal".

Normal birth is a professional category and could be equated with a diagnosis, even though diagnoses usually are applied to the sick. Normal birth is a category which in midwifery is distinguished from complicated birth. This division between the normal and the complicated was reproduced in the curriculum in the midwifery education program. During the first semester, the students learned about normality and in the second semester they focused on complications.

This chapter explores norms about normal birth. Norms about normal birth are interesting to explore because they not only show how the normal birth is constructed but also elucidate how midwifery students learn to perceive "their world", i.e. how to look at and understand birthing situations from a midwifery perspective. The distinction between normal and complicated births forms the basis of how they view pain, pain relief methods, feelings, life, and death. What they do in relation to what others (doctors) do constantly refers back to this distinction.

I will first discuss how a case description, called "Glimpses from a Childbirth", as I interpret it, illustrated various sequences of normal

childbirth, including the procedures carried out by a midwife and the patient-midwife interaction. It was discussed in two collaborative group sessions for first-semester midwifery students who had not yet been on practical training in delivery wards. I see it as providing a sort of baseline for their understanding of what a normal childbirth was supposed to look like. But, as I will show, normal birth is an elusive concept. As the teacher said during the student midwives' first lecture about normal pregnancies and childbirth: "It is only afterwards that one can tell whether a birth was normal". This uncertainty about what a normal birth is and what to expect was reflected in the students' discussions, both about the case description and later about their experiences in the ward.

The normal birth illustrated¹⁴

The case description is about Åsa Gren, a 29-year-old woman, who is about to give birth to her first child. She has been pregnant once before but miscarried. She comes to the delivery ward together with her live-in partner Magnus. They arrive now because Åsa has had contractions for the last six hours. A midwife called Sara Larsson receives them. Magnus hands over their birth plan.

Parents-to-be are encouraged to write such a birth plan – they are asked to write down their expectations about the labor, and their wishes or worries before coming to the delivery ward. Not everyone does this. The birth plan may include narratives of how they have experienced previous births, if the woman prefers certain pain-relief methods, if she wishes to give birth in a specific position, the partner's role during the labor process, and whether or not she wants to breastfeed the baby. Hence, it could entail a number of

¹⁴ I have reproduced the case description in a narrative form but included the quote by the patient in full, translated from Swedish. To translate the case word-by-word would not make sense to those who are unfamiliar with abbreviations and concepts applied in midwifery. I describe what these mean in a midwifery context and in relation to the delivery's status and progress.

things that the parents-to-be want the personnel working in the delivery ward to know.

The case problem continues by presenting results from the abdominal examination, vaginal exams, and technical notes. To establish the baby's position the midwife performs an abdominal examination, a palpation, where she moves her hands along the woman's belly. The midwife also conducts a vaginal exam to examine the status of the cervix and to estimate how far the baby's head has descended. These are practices carried out by the midwife during the different phases of delivery to determine its progress. From the palpation, midwife Sara finds that the baby lies in an occiput anterior position, which is the most favorable position. The baby is positioned with its head downwards and tucks his/her chin to the chest. In this position, the projected area of the baby's head is as small as possible as it rotates down the birth canal. In the outer examination, the midwife also finds that the baby's head is fixed in Åsa's pelvic brim. In the vaginal exam, the midwife further establishes the baby's position. The head is above the ischial spines, which constitute the narrowest part of the pelvis. The cervix is effaced, i.e. thinned out, and dilated 4 centimeters. The midwife uses a CTG device to measure the baby's heartbeat and the woman's contractions. The CTG device shows normal fetal heart rate and that Åsa's contractions come every 3-5 minutes and last for 45-60 seconds, thus they are strong and regular.

In their work, midwives proceed from a perspective that childbirth is divided into three different stages that categorize a delivery and thus its progress. The first stage is referred to as the opening stage of labor and is further divided into two different phases – the latent or early labor phase and the active phase of labor. The contractions during the latent labor phase are irregular, the cervix starts to dilate (up to 3-4 cm) and thin out (the effacement). The active phase of labor starts when at least two out of three of the following criteria are fulfilled: when the contractions become regular, which means 3-5 contractions per ten minutes, when the water breaks, or when the cervix is dilated 3-4 cm. The second stage of labor is called the expulsive stage. The cervix is fully dilated (10 cm) and the contractions change character into bearing-down contractions. The woman pushes and the

baby is born. The third stage of labor begins after the baby is born and continues until the placenta has been expelled (*The National Swedish Board of Health and Welfare* 2001: 17ff, *The Health Care Guide*, “The three stages of birth”).

At this point in Åsa’s case description, she has left the latent labor phase for the active phase. Åsa is now depicted as saying to the midwife,

I’m very pleased that I managed to stay home as long as I did. I rested, took several showers and time just passed. I’ve read about the birth but now I feel that I don’t know how to act. I’m used to being in control. I want a normal delivery.

From a midwifery perspective, the patient has interpreted the contractions in a “correct way”. If women come too early to the delivery ward, they may be sent back home to wait for the active stage of labor to begin. A further remark by the patient describes how she has experienced the labor process so far and how she wants to deal with the labor pain. Åsa wishes to have non-pharmacological pain relief, which assumingly is in line with her wish to have a normal birth. She and the midwife talk about possible choices and Åsa tries sterile water injections. These are supposed to decrease low back pain and increase the body’s production of endorphins. The midwife injects a small amount of sterile water into or under the skin on four points on the woman’s lower back. Åsa also tries a bath and warm wheat bags. Magnus gives her a massage, which also helps. Åsa believes that she can handle the contractions. The pain that she experiences has decreased.

Midwifery students learn that the warmth from a shower, a bath, or warmed wheat bags as well as physical closeness, such as massage, can help the woman to relax, decrease the pain and gain a positive birthing experience. This advice is also given to women pre-labor. Hence, that Åsa showered several times at home was done to help her relax and handle the pain, not for hygienic reasons.

Four hours have passed since Åsa and Magnus came to the delivery ward. Åsa’s contractions have increased in both strength and frequency. She feels nauseated and vomits. When the baby’s head passes the ischial spines in the

woman's pelvis, some women feel sick. The midwife examines Åsa and finds that her cervix is dilated seven centimeters and that the baby's head is at the ischial spines. Increasing contractions, nausea, and a continuously dilating cervix are considered to be signs of a delivery's progress. The CTG device registers the baby's heartbeat, which is normal at 144 beats per minute.

The midwife encourages Åsa to use the toilet because during the abdominal examination she could feel that Åsa's bladder is full. A full bladder could have an effect on the uterine contractions. Åsa's water breaks while she is in the bathroom.

After three more hours, Åsa starts to feel the bearing-down contractions. She pushes for one hour. The bearing-down contractions are usually described as a distinct pressure downwards with an irresistible urge to push. For first-time mothers, one hour of pushing is seen as normal from a midwifery perspective. It is usually a quicker phase for women who have given birth before.

A baby girl is born at 9.02 pm, in what is called vertex presentation, which is considered the most advantageous position and means that the baby has rotated down the birth canal and is born with its face in the direction of the mother's back. The midwife checks the baby's health immediately as soon as it is born. She estimates the baby's condition and gives it scores according to the international Apgar score system. This means that she looks at the baby's skin color, feels its pulse rate, checks its reflex irritability, muscle tone, and breathing. She gives points in accordance with a numerical scale (0-2 points) for each of these. This estimation is done three times at intervals of one, five, and ten minutes after the baby is born. The baby in the case description gets a total amount of nine points out of ten after the first estimation, which is considered normal. The midwife also draws a blood sample from the umbilical cord to evaluate the oxygen feed during the last phase of labor.

As an identity check, the midwife asks the woman to repeat her personal identity number and makes sure that it corresponds with the number in the medical record. The baby is immediately given his/her own personal identity number. The midwife attaches plastic bands with numbers around the wrists

of mother and child. The two plastic bands have the same numbers. The midwife also notes the numbers in the woman's medical journal. The plastic bands are not removed until the new family is ready to leave the hospital.

After the identity control, Magnus cuts the umbilical cord. That the woman's partner cuts the umbilical cord is merely a symbolic act. If the partner does not want to do it, the midwife cuts it. When the midwifery students practiced this procedure in a clinical skills session they were taught to place the umbilical cord over the palm of one of their hands in a way that should prevent emotional partners from cutting anything but the cord.

In the final paragraph of the case description, the placenta is expelled and the midwife sutures a rupture in Åsa's vagina and perineum.¹⁵ Ruptures often occur when the baby's head is born. The midwife sews smaller ruptures while the patient is still in the delivery room. The students learn that the placenta should be expelled as a whole within two hours; if not, there is an increased risk of bleeding. The midwife makes sure that the placenta is intact with no pieces left of it in the woman's uterus.

Certain things are not depicted in this "Glimpses from a Childbirth," but are still known to the students. While still in the delivery room, the new parents are served a traditional Swedish "fika", with coffee or tea, sandwiches, and a sparkling, non-alcoholic beverage. Afterwards they are moved to a maternity ward.

Another aspect that is left out in the case is the mother-child relationship. At the midwifery education program this was often spoken of with reference to attachment theory. Part of midwives' work is to support bonding between mother and child, both during the pregnancy and directly after the birth. Students learned that the baby should be placed upon the mother's chest soon after it is born to facilitate the bonding. Students also spoke of aspects that may affect the attachment of mother and child, such as the birth of a premature baby that may need immediate care and can not be placed upon the mother's chest.

¹⁵ Perineum is the area between the vagina and anus.

The normal birth as a trajectory

Explicit sequences of events appear in the story about Åsa and Magnus including physiological changes, what Åsa and her partner do and say, the midwife's interaction with them and the procedures that she carries out. To elucidate what that means in relation to a midwifery perspective of normal birth, I will use the concept of a *trajectory*, coined by Anselm Strauss. Wiener, Strauss, Fagerhaugh, and Suczek have studied birthing trajectories in a delivery ward and an intensive care nursery, with a focus on illness, and what they call "problematic, dangerous aspects of birth" (1979: 262). Thus, their focus was on illness and problematic situations. Later, Strauss et al. describe the concept of *illness trajectory* in the following way:

... [illness trajectory] refers not only to the physiological unfolding of a patient's disease but to the total *organization of work* done over that course, plus the *impact* on those involved with that work and its organization. For different illnesses, the trajectory will involve different medical and nursing actions, different kinds of skills and other resources, a different parceling out of tasks among the workers (including, perhaps, kin and the patient) and involving quite different relationships – instrumental and expressive both – among the workers. (Strauss et al. 1985: 8, italics in original)

Thus, the development and treatment of a disease – the *illness trajectory* – refers to the work conducted by those working with the patient as well as the apparatuses, medicines, and tools included in the care. Strauss et al. as well as others who have applied trajectory as a concept, have focused on the work carried out by the medical staff, which is both part of and shapes the illness trajectories (Strauss et al. 1985, Larsson 2010, Thelander 2001).

What concerns me here – and the students at the midwifery education – is, however, not illness trajectories but *normal birthing trajectories*. This means three important differences from previous studies. First, midwives proceed from the assumption that pregnancy and birth are normal; it is not some illness that needs to be cured. Second, all patients who come to the delivery

ward are there for the same reason; they are pregnant and about to give birth. Thus, midwives expect them all to follow more or less the same trajectory. In comparison, Larsson and Thelander show in their studies how doctors and nurses meet patients with different diseases and thus also different expected trajectories.

The third difference concerns the patient's role in the trajectory. In a normal birthing trajectory the patient is the one expected to bring the trajectory forward. In contrast, the patients' active participation is not in focus in the work by Strauss et al. and others who have looked at illness trajectories. In Strauss et al.'s study, patients' participation is mentioned only in terms of them cooperating with the healthcare practitioners. In Larsson's thesis about anesthesiologists' hand-over talks, the patients are neither present nor conscious. The doctors discuss the patients' futures based upon what is often meager information from medical evaluations and relatives' accounts. In Thelander's study, it is the doctors and nurses who work to help cardiac patients wake up and return to the lives they had before cardiac intensive care. Thus, in these studies patients are largely passive or unconscious and have work performed on them. Midwifery patients, in contrast, are expected to be active participants in labor.

Based on the story of Åsa and Magnus, three aspects of the normal birthing trajectory can be brought forward. The first is the "organization of work", that is, what the midwife does, which technology is used, and where the birth takes place. The second aspect is what Strauss et al. call "the physiological unfolding," that is, the woman's bodily changes during the labor process. The third aspect concerns the work done by the patient. These aspects are of course intertwined; what the patient does is related to the bodily changes, the medical categorizations of bodily changes and labor stages, and to how the birthing situation is organized. But it also includes how the woman, in a normal birthing trajectory, is expected to experience the labor process bodily and emotionally.

Norms of the normal birthing trajectory

In the story about Åsa and Magnus, the normal birthing trajectory begins when Åsa's labor starts at home, continues in the delivery ward, and ends with the couple becoming a family of three and with the aftercare procedures that the midwife carries out. There are other parallel and partly overlapping trajectories, such as a pregnancy trajectory and a parental trajectory.

As noted above, to understand a normal birthing trajectory, the organization of work is important. It concerns not only the work done, and by whom it is done, but also the setting in which normal birth takes place and the technology used. Wiener et al. call these aspects their *biography* (1979: 261ff). These could be the history and practices of a particular hospital ward as well as the previous experiences of those involved, as they affect the trajectory. I will use the concept to elucidate certain aspects to be found in the fictive case description about Åsa and Magnus but these aspects are also part of the general understanding about births in Sweden.

That birth in Sweden normally takes place in delivery wards affects the perception of normal birth and the work and actions that can be done during the birthing trajectory, for instance with the kind of technology available there (which has a biography of its own). Planned home births are rare in Sweden and are seen as involving higher risks than hospital births (Hellmark-Lindgren 2006: 199ff). A patient is thus expected to move between different places depending on where she is in the labor process. She should leave her home and arrive at the delivery ward when she is in active labor. When the baby is born, they should transfer to a maternity ward.

Midwives handle normal pregnancies and births with the help of an assistant nurse and/or an additional midwife (who was left out in the case description). Doctors are only included in the birthing process when the midwife detects a deviation. Normal birth is a vaginal birth and something that both midwives and doctors strive towards. Women have to fight hard to have a caesarean section if the midwife and doctors do not believe there is a medical reason for it (Hellmark-Lindgren 2006: 157ff). This norm, that vaginal birth is

the desirable outcome of pregnancy, is reproduced in the case story about Åsa's experience.

The case does not tell much about the midwife, what Wiener et al. call a "staff biography." The only thing the reader learns is that her name is Sara Larsson. Nothing is told of her previous work or of how she experiences helping Åsa and Magnus through the birthing process. However, both the midwife's name and the name of the patient and her partner, Åsa Gren and Magnus, reproduce expectations about Swedish ethnicity. The biography of Åsa and Magnus also reproduces other norms of the common or ideal expectant parents. Åsa is well prepared, having taken showers to ease the pain and waited until the right moment to arrive at the ward. Åsa and Magnus also appear as a couple who have prepared for labor together, as shown by Magnus handing over *their* birth plan. The story reproduces a heteronormative ideal and also the ideal that the couple becomes a family in the delivery ward. The baby's state of health and the fact that it is a baby girl, i.e. a definable gender, is significant about the baby's biography.

There is a photo included in the case description. It shows a couple in a delivery ward. The woman is lying in bed with the CTG appliances strapped around her belly. One registers her contractions and the other the baby's heart rate. A man is sitting beside her, looking at her and holding her hand. There is a striking similarity between this photo and the photo shown at the first lecture that I and the students attended. Both photos show images of heterosexual couples who share the experience of pregnancy and birth; the men in the photos look at the woman and/or touch her and thus are given central positions.

Åsa, Magnus, and midwife Sara can be seen as representatives of ordinary people who do not distinguish themselves as different in any way. All in all, however, the biographies are quite meager. Wiener et al. explain that what is included in a biography is what the staff finds important in the encounter with patients (1979: 268). In line with this idea, the case description only gives the students relevant information for them as midwives. Åsa's and Magnus's biographies show that they are normal patients with no known risk factors. However, certain aspects of Åsa's biography may seem less evident, but can

be seen as being normalized in the story. Åsa has miscarried before, which is considered a normal experience that a woman may carry with her into a normal birthing trajectory. It is not ideal to get ruptures in the vagina and perineum, but it is common, as are previous miscarriages. Hence, some norms concern what is common but not ideal.

If the case instead had described Åsa as an older or younger first-time mother, it might have brought about a discussion among the students about how age matters and the risks it might involve. Hence it would not have been about a normal birth, which it was supposed to be. The biographies in a case description are thus geared towards what is considered the most *common* aspects of the particular situation – in this case a normal birth – to be discussed. As I have shown, these tend also to be normative in the sense of the *ideal*.

Concerning the physiological unfolding of a normal birthing trajectory – the second aspect above – Åsa's delivery is seen as regular from a midwifery perspective. This concerns how long the different labor stages last, the intensity of the contractions, the pace of the progression including cervix effacement, dilation, and the changing position of the baby. Åsa's labor started spontaneously with contractions and the water also broke spontaneously. Her labor progress continued normally, as did the expulsion of the placenta. The time added up to fourteen hours altogether, including one hour of pushing, which is normal for first-time mothers.

The medical definitions of the different stages of labor thus become a way of reassuring that the labor continues along the normal birthing trajectory. Maureen L. Sookhoo and Colin Biott (2002) show in their study that the procedures that midwives carry out during the labor, and especially the estimation of how the cervix dilation, is a way to ensure normal progress. Together with other exams and technological monitoring the midwives thus avoid uncertainty about the delivery's status. However, Mandie Scamell writes that what she calls "routine surveillance practices" actually increase uncertainty because the midwife puts her trust in these practices and has trouble picturing a normal birth without it (2011: 994). Hence, just as shown

in the Åsa and Magnus case, the hospital setting, examinations and technology applied become parts of the normal birthing trajectory.

The story depicts both the woman's bodily changes, her actions, and how she emotionally approaches birth. Åsa appears to be someone who is well prepared and interprets her body continuously in the "right way". She knows how to recognize when the labor begins and how to handle the opening stage of labor at home and she arrives at the delivery ward when she is in active birthing mode. She expresses that she wants, what from a midwifery perspective is a normal birth, i.e. a vaginal birth. She is then active during birth, communicates with the midwife, and expresses a wish for a normal birth with only non-pharmacological pain relief methods. With the support of the midwife and partner Magnus, she handles the birthing pain well and gives birth to a healthy baby girl.

It is thus not only the birthing woman who ideally takes an active part in the normal birthing trajectory. Magnus is an active partner. He is the one who hands over *their* birth plan, where Åsa and Magnus together have written down how they want to experience the birth of their child. He is active during birth as well, giving the birthing mother massage and finally cutting the baby's umbilical cord. That is, Magnus and Åsa give birth together and at the moment of birth, they become a family.

At the midwifery education program, teachers and students continuously emphasize that it is the women who deliver the babies, not the midwives. When Åsa says, "now I feel that I don't know how to act", it indicates that the role of the midwife is to support Åsa at certain stages in the normal labor process. Although midwife Sara is not the one who actively brings the birth forward, she is still needed. She estimates dimensions of pain and offers the kind of support that the birthing woman and her partner require. The midwife also continuously checks the health of mother and baby. She monitors it to reassure that it stays within normal limits. The midwife registers the cervix dilation and the position of the baby's head in relation to time. If the birth is not progressing at the expected pace, she calls on a doctor who can decide whether interventions are needed. They may then decide to make the water break artificially or give the woman a hormone-like substance to stimulate the

uterine contractions. Most often it is the midwife who performs both kinds of interventions. The interventions aim at making a labor process that is not following the normal pace of progress turn into what is seen as normal. In these cases, the midwife's role changes from a merely supporting one into a more active role. However, in a normal birthing trajectory, non-intervention is seen as the ideal. The normative assumption in midwifery is that it is the woman who does the work in birthing and the midwife supports her.

To sum up, the normal birthing trajectory is both complex and simple in this case description. A normal birth includes concepts about where it takes place, with whom and how. Midwifery students learn that, in Sweden, normal birth takes place in a hospital. The pregnant woman arrives with her partner and they will become a family. Included in the normal birthing trajectory is a sequence of bodily changes, intertwined with various emotional experiences. With the support of a midwife and her partner the birthing woman manages to handle the pain with only non-pharmacological pain relief methods. The woman is active in birth. The health of mother and child is good. As long as the pregnancy and birth follows the expected trajectory, it is categorized as normal. These are cultural as well as medical expectations. They are ideal assumptions about normal birth as well as norms about what is common but not ideal.

The story told the students what to expect of a normal birthing trajectory. It should help them when preparing for a birth and during the labor process. But – as the teacher said – it may be that one can tell only *afterwards* whether a birth was normal, or not. I now turn to how this dilemma was understood and handled by the students and how do they together tried to assess the norms of the normal birthing trajectory.

First semester students searching for the normal birth

The Åsa and Magnus case was discussed during two consecutive collaborative group sessions. The students decided to read about the opening stage of labor for the first session and about the expulsion stage for the second. The students brainstormed on the case, wrote down terms used in the description and different examining procedures carried out by the midwife, such as abdominal examination. The research question that they formulated together was how to recognize what physically happens during the labor process. Much time was spent on trying to understand the different terms signifying the possible positions the baby might have in the uterus, how its position affects its rotation down the birth canal and the position in which it is born. Thus, they focused on the physiological aspects of the labor process and paid no attention to Åsa and Magnus.

This does not mean that students never talked about how a woman and her partner may experience pregnancy and birth. When these first-semester students were to discuss this case they had just finished an assignment about “transition,” which took up how labor and birth affect the everyday lives of the parents involved and how they experience those changes. But the students did not bring these insights to the discussions of the case description about Åsa and Magnus. Instead, the students were focused on how to recognize and handle the bodily changes that were part of a normal birth.

This focus can be seen in the light of their upcoming work in a delivery ward, their first experience of attending births. Shortly after these first-semester students had discussed the case description about Åsa and Magnus, they went for their first five weeks of practical training. Four of the students in the group were going to practice in delivery wards and the other three were going to share their time between a midwifery clinic and a maternity ward. All but two of them had given birth themselves, and one of the two without children had previously worked in a delivery ward as an assistant nurse. Nevertheless, this was to be their first experience of birth from the perspective of a future midwife.

I met again with the students when they returned from their practical training. When they talked about their initial experiences of practical training in clinical sites, they spoke of the patients in terms of normal and complicated pregnancies and deliveries. They had expected to meet patients with normally progressing births, as this was what they learned about during their first semester. When they spoke of how many births they had attended they referred to the conditions set by the school. They were required to attend approximately 100 labor processes before graduating. Fifty of these were supposed to include the birthing moments and the other could include handling parts of the labor process but then passing it on to another midwife.

Thus, to be able to count the number of births they had attended, the students had to follow the labor process until they could receive the baby when it was born, i.e. to the end of the birthing trajectory. That this was not easily achieved; the fact that normal births that are not interrupted for some reason may not be so common after all, was reflected in their reactions at the first session after their period in the wards.

Before the session, I spoke with Frida who happily declared that she had participated in seventeen deliveries, that is, she counted the final phase of the birthing trajectories when the baby was born. Another student told a different story:

Magdalena I had some trouble with the number of patients I saw. For a long time, I had only handled four deliveries, and it went on like that. We thought we got the right patients, but they were all drawn-out labors. This stressed me out, but finally I got twelve of them.

Teacher Were you there this weekend as well?

Magdalena Yes, but again I had labors with vacuum extractors¹⁶ and draw-out deliveries. They [the midwives working in the ward] said that I would become an expert on these situations.

¹⁶ Vacuum extractors are used, for example, when the delivery needs to end quickly, or if the mother no longer has the strength to push the baby out on her own. Usually, doctors

The midwifery teachers as well as other midwives in the wards try to organize so that first-semester students meet patients with normal pregnancies and childbirths, “the right patients” who have “normal births,” as that is what the students had learned about so far and what they were to practice in the delivery ward. And “normal births” were what the students expected. However, Magdalena and her supervisor had been given patients who did not give birth before the shift ended, or were delivered with vacuum extractors, which meant that a doctor intervened. Thus, Magdalena could not practice how to support the woman the way she would do during a normal vaginal birth and she sighed in frustration when she narrated her experience.

The excerpt above shows that the students distinguished between normal and deviating labors, and classified labors as either normal or not. But, as the example also shows, midwives cannot always estimate from the beginning whether a labor will be normal or not; it may turn out to be quite different from what was expected.

Another student had a very different experience from Magdalena’s:

Deniz I was also in a delivery ward. But I didn’t have the kind of deliveries that Magdalena had. Everything went well. I began my practice mainly with women who’d given birth before and some of the labors went really fast, for some women only two or three minutes. But it takes longer with first-time mothers. In those situations, you train your patience, you just stand there by the woman’s side, watching and advising her to change position to give the baby more space to come out. It is a worthwhile experience. I had sixteen deliveries and one caesarean section ... This was really fun. But I didn’t have any complicated deliveries.

manage the vacuum extractor although midwives should know how to do it if necessary. Drawn-out deliveries probably meant that the delivery did not progress at the expected pace and that the midwifery student’s shift ended before the patient gave birth.

Just like the other students, Deniz spoke of the number of births she had attended. And just like Magdalena she mainly spoke of birth as having to do with the physiological aspects of the birthing trajectory. Deniz however also included parts of the patients' biographies in her narrative, indicating that women who have given birth before have a fast birthing trajectory, whereas the deliveries of first-time mothers take longer. Deniz also mentioned the midwife's role as being a supportive one. In doing so, she did not refer to emotional support but rather to giving the women advice on how to move around to facilitate the bodily birthing progress.

When the first-semester students narrated their initial experiences from delivery wards, they seemed to focus on parts of the birthing trajectory that they interpreted as constituting a normal birthing trajectory, for example that there should be no doctors involved or no instruments such as vacuum extractors or forceps. This was in line with the demand that they should attend until the birth of the child. However they also realized that, although there are correct stages of a normal birth, the different stages could sometimes pass very quickly without the birth becoming problematic or categorized as complicated.

Second semester students widening the perception of normal patients

In collaborative group sessions, the case descriptions of pregnancies and deliveries to be discussed were categorized as being either normal or complicated. They became increasingly more complex during the second semester; thus the students got a more diversified picture of what made patients belong to one or another of these categories. In this way, they learned about how to interpret births as midwives do.

As the students went on with their education and their experience increased, their perception of normal birth therefore changed. They got a more diversified picture of their work and of what they might meet in the delivery ward. I will exemplify this with how second-semester students negotiated what would be a "normal patient" and how they should relate to

different patient biographies, as that has an impact on their conceptions of a normal birthing trajectory.

The students and teachers often spoke of working with women with different backgrounds and livelihood situations, and of how that would affect the midwife's encounter with them and how she carries out her work. For example, midwives expect patients in the delivery room to be comfortable with nakedness, or at least accept being naked during the final part of the birth. A teacher brought up that not all women want to be naked. She said that Muslim women presumably would want to keep their bodies covered. In the encounter with a patient with this wish, midwives therefore should change the routines of how to prepare the woman's body before placing the child upon her chest and encouraging it to search his or her way to the mother's breast.

There were also other aspects brought up about the patient that might affect how a midwife perceives the "normal patient". Not all patients bring their male partners to the delivery ward as Åsa did. That a woman might bring with her a female partner was a non-issue in the discussions I observed. When students and teachers happened to say husband or father instead of partner, they often corrected themselves. The norm at the midwifery education program was that gender does not matter. The birthing woman and her partner always become a family at the birthing moment. The formation of a new family is however of great significance. As Shirley Näslund (2013: 5ff) shows in her study of social interaction in the delivery room, the father's cutting of the umbilical cord can be seen as a symbolic act marking both the physiological separation of mother and child and the creation of the new social entity of a family. Näslund compares this with the ceremonial act of cutting a ribbon at an inauguration.

But women who do not bring a partner at all may disturb the norms about what constitutes a normal birthing trajectory. A woman who brings a female relative instead of her partner challenges the perception of the birth as a family-creating occasion. This kind of situation was discussed among midwifery students mainly in connection with foreign-born women – even though it should be emphasized that it is not only foreign-born women who

bring with them someone else than their partner. Such a situation was pointed out as something that they had to think about.

The following exchange took place at the end of a session when the second-semester students had begun to prepare their reading on a case problem about complicated pregnancy and birth. They spoke of the different aspects that they needed to cover, how the woman and baby might be affected by the complications, and how they as midwives should work with support and empowerment to help such women. The teacher present at the session added that they should not forget a cultural perspective. This resulted in the following exchange:

- Sarah While we're speaking about cultural differences, I had two Iraqi women who gave birth. One of them had her mother-in-law with her and the other one brought her husband's aunt.
- Cecilia I've been thinking about that, that it might be helpful to have another woman there who has given birth herself, instead of a terrified father. Because then she [the accompanying woman] can say 'this is how it is'.
- Sarah But at the same time, one of them didn't speak Swedish so eventually it became difficult to maintain contact with the birthing woman. I almost had to make her [the accompanying woman] back down. Besides, who would want their mother-in-law at their delivery?

Both Sarah and Cecilia show that bringing relatives into the delivery room deviates from the norm. It is something they have reacted to as different but they took different positions in how they talked about it. The fact that Sarah seemed to question having one's mother-in-law attending the birth may have collided with her perspective on a proper birthing situation. And assumingly she would not prefer it. Meanwhile she reproduced the norm that patients are expected to bring their partners with them and that midwives should help the new parents and the baby to feel like a family. The situation she told of in the excerpt clashed with the norm that the birth was a question of a threesome,

something often mentioned in the stories told by students, teachers, and in course material. Similar stories were narrated by other students as well.

Cecilia confirmed that bringing relatives into the delivery room is different from the partners in most births. However, she opened up for a negotiation about norms concerning whom to bring to the delivery. She brought forward the benefits of having an additional woman in the room who could offer support to the birthing woman. But this affects the midwifery perception of normal birth, if there is no new father there to cut the umbilical cord as a symbolic act of the couple becoming a family. Instead Cecilia focused on the supportive role of the accompanying person, who in her view could just as well be someone other than the father. In fact, a woman who has gone through birth herself might actually be more supportive than a father who is scared and assumingly not helping as much as the midwives would want.

Hence, a patient's biography, her choice of person to bring to the delivery, her background or culture, were mainly mentioned when presented as affecting a midwife's encounter with the patient. The students did not speak of this kind of situation as a problem but rather as a different kind of choice, however accentuating it as strange. The birth would still be considered a normal one.

Discussion

In this chapter, I have discussed norms about what constitutes a normal birth. In the case description distributed to the students to give them a "glimpse" of a normal birth, different norms about normal birth can be detected. Birth is constructed as a trajectory, a predictable sequence of events, with certain expected bodily and emotional experiences as well as actions by different persons and apparatuses in accordance with a medical perception of the different stages of labor, and with a healthy baby and a family as a result. The normal is, however, complex. It has several different meanings to it: "the usual" or the statistically common, and the normative (Koeslag 1993: 47f, Sandell 2001: 26f). Thus, in the image of the normal birthing trajectory,

perceptions of “the usual”, and “the ideal” are intertwined, but also challengeable.

The distinction between the normal, or healthy, and the deviant, sick or pathological is a common one within medicine. Several scholars have studied the normal and the pathological in relation to the female body and provided insights into the complexity of the normal, how normality is constructed in practice and in patient encounters, and how it can be problematized (Sandell 2001; Koeslag 1993).

In many ways it seems that the normal in midwifery is somewhat different. Midwives work with women who are seen as being in a normal phase of life; giving birth is after all considered a very normal aspect of a woman’s life. Since the patients are not ill, the midwives’ work is not to care for them, but rather to support them in their labor.

However, it is still important for the midwives to categorize divergences. The students learn that in real-life birthing situations, a midwife needs to continuously interpret what happens during the labor process to establish whether it is normal or not. The women’s positions as patients are complicated. I have chosen to refer to them both as birthing women and patients because that is how the students talked about them. Mandie Scamell draws upon the work of De Swaan when she calls the birthing women “not-yet-patients”. The pregnant women are considered to be normal and healthy but at risk, hence the need for “health surveillance” (2011: 989).

Thus, the students learn how to categorize births as either normal or complicated, and have to understand how to interpret the signs of a deviation and reflect about what may not be as important as the case description indicates. In Chapter 6, I will discuss how the students interpret when the trajectory does not seem to evolve as it should, what signs to look out for, and what action to take to bring the trajectory back to a normal path. But before that, I will explain more about the midwives’ role in a normal birthing trajectory. I will discuss that in the following chapter.

5. Feeling like a midwife: negotiations of professional feeling norms

Prologue: Attending one's first childbirth

"I wept when I saw my first childbirth, it was so beautiful", the midwife said.

It was my first day on the delivery ward and we were walking at a quick pace down the hallway towards one of the delivery rooms. The midwife smiled at me, with enthusiasm in her eyes. I returned the smile, and hoped to be able to stay focused when we entered the room. I was about to observe childbirth for the first time and did not know what my own reaction would be. I was both anxious and excited.

When we entered the delivery room, I stayed close to the foot-end of the bed and put my hands in the pockets of my green scrubs. From where I stood I saw the woman who lay in bed and her husband standing close to her, the midwife who sat at the foot-end of the bed, the assistant nurse standing beside her, and the monitor that indicated the baby's heartbeat and the woman's uterine contractions. The woman's contractions seemed to be strong; she stiffened when they gained in intensity. Her husband held his arms around her and whispered something in her ear while she breathed through the pain with the nitrous oxide. The midwife frequently glanced at the monitor. She examined the woman between two contractions, said that the cervix was fully dilated and that the woman could start pushing. The husband looked pale. The midwife asked him if he wanted to sit down, but he said that he was fine.

Then something changed, and I saw the baby's head slowly appearing. With a calm and steady voice, the midwife encouraged the woman to keep up the good work. The midwife placed one of her hands below the vagina to

support the perineum¹⁷, in a grip I later learned is called perineal protection, used to prevent ruptures. With her other hand placed over the baby's head it looked to me as though she pushed the baby back in. Then she changed her grip and placed her hands around the baby's head. With a more direct voice, she told the patient to push harder. In a few moments, the baby was born and started to cry.

This first experience of watching childbirth affected me in several ways. I was overwhelmed by everything I tried to memorize, relieved that I managed to stand there focused through the whole process, fascinated by how fast the labor process had gone, and also privileged to have had the opportunity to observe a childbirth up close without having to do any of the work myself. However, I was not moved to tears.

This prologue derives from a few days of delivery ward observation that I carried out before my field work in the midwifery education program. In the opening quote, the midwife said that she started to weep when she attended her first childbirth. It is reasonable to assume that she, once a midwifery student but now an experienced midwife, and I, a doctoral student within the social sciences, entered the delivery room with different expectations as well as differences to what we directed our attention. When the midwife whom I observed in the delivery ward attended her first birth, she faced a situation that she soon was to manage on her own. I, on the other hand, focused on observing what happened in the room, memorizing it so that I later could write detailed field notes and describe a birth in a delivery ward in Sweden.

There may be several different reasons why the midwife told me that she wept when she saw her first childbirth; she may have wanted to indicate that she would be sympathetic to a similar reaction from me, or that she expected

¹⁷ The perineum is the area between the vagina and the anus. Ruptures often appear there when the baby's head is born. The midwife works to decrease the risk of ruptures. She especially tries to prevent severe ruptures that could damage, for example, the muscle around the anus.

the situation to affect me in a similar way. The midwife's utterance could also indicate that different feeling norms applied to working midwives and to inexperienced midwifery students (and of course different feeling norms applied to me). She could have meant that to weep the *first* time one attends a birth is allowed, but thereafter one should control those kinds of emotional expressions. Of course, this does not imply that birthing did not affect her anymore. But a birth does not affect her to such a degree that it brings her to tears.

Midwives' work in delivery care can be described as intimate and emotionally intense. They help women who experience pain, fear, anxiety, hopefulness, and joy to give birth. Their work includes both life and death. No matter what the situation, midwives are expected to maintain a professional attitude whilst caring for the child and soon-to-be parents (Hunter 2001: 436f). Peter Duncan et al. explain the importance of learning both professional skills and a professional attitude.

They [the practitioners] may be technically competent, following all the rules, but nevertheless lack a certain disposition towards their patients or clients – the disposition of the 'good practitioner'. (Duncan et al. 2003: 182)

Duncan et al. also dismiss "caring" as too vague a concept to describe the attitude towards the patient. Rather, as I would phrase it, one's appearance as a professional includes certain *feeling norms* of the "correct" emotions in different situations. In this chapter, I will explore how midwifery students negotiated the proper way to approach a normal birth situation, and thus to be a "good" midwife. I will show that it is not self-evident what the appropriate professional feeling norms are; they are negotiable and also change over the course of a midwife's professional life. However, even in relation to a joyful event, such as a normal birthing trajectory, the right professional attitude seems to be one of restraint, of being moderately happy and properly proud.

To be moderately happy when babies are born

My first experience of observing childbirth was an exciting experience. I was there as a doctoral student in the social sciences to observe midwifery work in a delivery ward. I tried to act as I thought an anthropologist in the field would act, which meant staying calm and not fainting. To attend a first childbirth as a midwifery student ought to be different from my own experience. And presumably we have different expectations about the situation.

In witnessing their first births, the midwifery students encountered what they are about to work with in their coming profession. I heard midwives and midwifery students speak a number of times about this first birth, typically in terms of weeping because one finds a birthing situation beautiful.

To get more insight into whether this was a proper way to act, I invited four of the second-semester students to sit down with me to do a group interview. I started out by asking them to describe the first birthing they attended, since I believed that this was something a midwifery student would remember. How they depicted their first births, I thought, would say something about how they viewed the way a midwife should behave. It might also say something about whether the norms changed during their learning process of becoming midwives. As first-semester students, they expected to encounter only normal births because that was what they had learned about so far, but by the time of the group interview, the students had learned about complicated pregnancies and birth. This additional knowledge might make them think differently about their first birth.

As it turned out, this was correct. How they narrated their experiences show their expectations that their first experience would both be one of a normal birth and that they would experience it as a beautiful moment. However, these expectations were not fulfilled for everyone. The following stories show the diversity of the students' first experiences of birth:

Helena It was an emergency caesarean section, which is not a good example for a first childbirth. I got this-, well, it was a shocking experience to me. I couldn't really understand what

- happened. I thought ‘oh, so this is how babies are born’ [she said in a troubled voice]. I got the wrong picture.
- Sarah I had the exact opposite experience. It was a woman from Somalia giving birth to her seventh child. It was born in the wink of an eye and I thought ‘Oh, so this is how it is to work as a midwife, what fun!’ She had no pain relief, nothing. She just pushed two or three times and then there was a little baby. And I wept, I thought it was so beautiful!
- Helena I wept too, but because I was scared! [She smiled when she said this, and made us all laugh.]
- ...
- Helena In my book, my supervisor wrote ‘this was a shocking experience for Helena’. Yeah, it was very professional of me to weep [she said ironically].

These students brought up different aspects about how to experience the first birth. One referred to expectations that the first birth should be normal. Students were usually delegated presumed normal pregnancies and childbirths during the first semester, which means deliveries without any known complications. However, an emergency caesarean section is hard to foresee. (I showed in the previous chapter that normal birth might also be difficult to predict). Another aspect refers to the emotional experience of the birthing situations. A third aspect refers to the students’ learning process and how they related this experience to understandings of what it meant to work as midwives.

Being moved to tears when attending the first birth as a midwifery student seems to be something that was allowed and perhaps even expected. In the excerpt above, both Helena’s and Sarah’s stories included weeping. Sarah’s story was of a normal (beautiful) birth that moved her to tears, thus her story confirmed the idea that it was normal to be moved to tears during one’s first birth as a midwifery student.

Helena also told a story about weeping, but in quite a different way. The birth she attended was not a normal birth. She was not moved to tears by the

beauty of the birth. She was scared by a critical situation that had lead to an emergency caesarean section, and that was why she wept. But a midwife should not weep in such a situation; crying should only be done in relation to a beautiful normal birth. Helena therefore told her story about how she cried out of fear in a way that made the group laugh. This was perhaps done to distance herself from who she was then, an inexperienced midwifery student who cried because she was scared and thus broke a norm. Helena also distanced herself from the emotions she had expressed in the situation, by describing her supervisor's response; a professional midwife should not be shocked and weep during a complicated birth. With her ironic remark, she indicated that she no longer would become tearful in similar birthing situations.

When I asked the students if they felt that they should weep when attending birth, one of them responded in the following way:

Cecilia I thought, 'No, I'm not going to weep!'

Cecilia emphatically did not want to act in the expected way, which is that a midwifery student weeps at her first birth. She had decided beforehand not to cry during the first birthing. When she said this, she showed that she had reflected upon it before and thus was familiar with the feeling norm of weeping at one's first birth. But she chose not to act in accordance with it.

Expectations about being moved to tears when seeing one's first childbirth were, it seems, shared by the students even if not everyone experienced it (or wanted to). Drawing upon the work by John Leavitt (1996), I see feelings as both collective and individual. Persons in a group will have similar experiences because of their similar situation and what he explains as "shared expectations, memories, and fantasies" (Leavitt 1996: 527). Weeping during the first birth was something they all could relate to. Thus, as Leavitt points out, their feelings were not randomly evoked.

Midwifery students had together prepared for practical training in delivery wards; they had all read about and discussed normal birth. They had been thoroughly exposed to the notion that it is the women who do the work

in birthing and that it is the midwife's job to support the woman through birth and make sure that the birth follows the normal birthing trajectory. In the previous chapter, I showed how first-semester students¹⁸ in their courses and discussions had learned about pregnancy and childbirth as normal and beautiful events in life and thus what moved them to tears.

However, one of the students had decided not to start weeping at her first birth. Hence, even though she was part of the same group as the other midwifery students she decisively opposed acting according to the expectations. Leavitt writes that even though everyone knows the collectively felt emotions, not everyone experiences those feelings. In fact, some have strong feelings against what it is they are supposed to feel in a given situation (1996: 527). Hence, a person can for different reasons oppose the collective norm about how to feel. In the Cecilia's case, it may be of importance that this student was the only one that I had so far heard talk about not wanting to work in a delivery ward. She considered working in delivery care as only seeing patients of similar age who are there for the same reason, which meant that she as midwife would carry out the same kind of work every day, something which she did not want to do.

It became clear during the discussion that different feeling norms apply to the inexperienced and the experienced midwifery student. In the narrative of the first births told by Helena and Sarah, both distanced themselves from how they had reacted earlier. Thus, Sarah made fun of her first experience, when she thought that to work as a midwife would always be as easy as with the woman who gave birth for the seventh time. Similarly, Helena made an ironic remark about how she got a picture about "how babies are born" – through emergency caesarean section – and about her crying in a critical situation. Thus, they distanced themselves from their first, erroneous, perception of childbirth to show that they now had come further in their education and in their learning process.

¹⁸ Even though the first-semester students I observed consisted of students who started the year after the group of second-semester students, it is reasonable to assume that they discussed the same things about normal birth.

As Hochschild has also noted, norms, or rules, change with a person's position; "When roles change, so do rules for how to feel and interpret events" (Hochschild [1983] 2012: 74). The main difference between the students' roles during their first birth and that of the following births in which the students participated, was that they were expected to learn more about the practical aspects of midwifery later in their education.

But it is not only a possibly erroneous perception of childbirth that makes the first birth different from subsequent ones. As was made clear during the discussion in response to my question about what feelings the students were expected to have when attending births, similar reactions to that of the first time – of joy or shock – would not be accepted now that they were more experienced.

Jenny But do you feel that you should weep?

Sarah No, not now since there are so many things to do and be observant of. But at that time [at her first birthing] it was just, 'oh!'

Sarah argued that a professional midwife should be attentive to "the many things to do and be observant of". Emotions should not interfere with their responsibilities. According to the students, the demands for a proper control of their emotions seemed to increase throughout the education and as their responsibility increased. They could not let themselves be emotional when a child was born. Instead, they should focus on their responsibilities and attend to the routine work of aftercare. Thus, Cecilia explained that she now thought more about what to do next, such as to give the patient oxytocin so the uterus would contract. She had not thought so much of those things the first semester when she was less experienced. Ellinor added that they now did not have the time to be affected in the way that they were the first semester. Tears interfered with the routines but the opposite was also true; the routines kept them busy and prevented them from becoming teary-eyed.

However, feeling norms are more complex than to say that you may or may not weep while carrying out your work. There were other situations

brought up by the students when being teary-eyed would be all right. In the following excerpt, the discussion of whether or not to become teary-eyed no longer refers to the first birth. It shows that it is not obvious to the students what the proper norms about showing emotion through weeping (or not weeping) are in different situations, and that they tried to figure it out together.

- Helena I would say that it [whether or not one can be teary-eyed at the birth of a child] depends on the situation, if there is something special.
- Jenny Special in which way?
- Helena Well, not if it is a really traumatic situation, but if it's a situation where you think that in the end it turned out fine, something like that.
- Ellinor I think I had to bite my lip the whole first semester to stop myself from being moved to tears, and occasionally wipe away a small tear because it is so beautiful and amazing.
- Helena It depends on the parents' reaction too.
- Ellinor Yes, if they are happy and if the fathers are affected and moved by it.
- Sarah Oh yes, the fathers! When they begin to weep and when they say 'oh, honey, it's a girl!' [She said this in a voice indicating being moved to tears of joy]
- Cecilia And then we interrupt by saying 'now let's see if you got any ruptures [in the vagina and/or in the perineum]. And we ruin the moment. [Everyone started laughing at the way she said this]. But you can't stand there looking grave.

Ellinor had to control herself during the whole first semester because she found births so beautiful and the students agreed that, even though they were more experienced now, they could still be moved to tears – but only if it was for the right reason.

Not everything was negotiable, however. To weep in a traumatic situation would not be professional, as Helena's remarks above also show. Cecilia's comment shows two things: first, how her work keeps the midwife busy and gives her no time to be affected by the birth, and secondly that she has to be careful not to destroy the parents' joy by "looking grave" and talking about how she must continue her sometimes painful or disruptive work. Thus, one should not seem too serious, either.

In the midwifery students' discussion, three aspects are present of what Hochschild has discussed as characteristic of feeling rules. She argues that feeling rules are about "the *extent*", "the *direction*" and "the *duration*" of what should properly be felt in a given situation (1979: 564). One can experience too intense or too weak a feeling in relation to the norm (or, in Hochschild's words, a rule), hence the extent of the proper feeling is important. The direction of a feeling concerns having the right kind of feeling. Hochschild exemplifies not experiencing the expected kind of feeling and explains it thus: "one can feel sad when one should feel happy". Finally, duration is about for how long a feeling ought to last in relation to what it is directed towards. To sum up, norms about feelings concern how intense a feeling should be, what one should feel and toward what.

The students discussed what Hochschild calls the extent of a rule – how intense a feeling they were expected to express. A normal birth should from a midwifery perspective consistently be seen as something beautiful that could move an attending midwife to tears. However, the expectation of experienced midwives was that they should not become too affected – they should experience and express a moderate happiness appropriate to the situation. All students agreed that a midwifery student could weep the first time (if it was a normal birth) but thereafter she should not become overly affected. Nor should she look too grave or serious; thus the right kind of feeling must be expressed. This meant that they needed to negotiate their feelings in relation to the situation. To weep was possible, if a birthing situation turned out to be special, in a critical situation turned around for the better, in response to the parents' or the father's reaction.

To express moderate happiness seemed to be the general norm, for practical reasons also. Too intense emotions the students spoke of as interfering with the work. The routine of work could in turn also help them not to become overly affected. Attending to routines in delivery care then functioned as what Hochschild calls *rule reminders* (Hochschild [1983] 2012: 57, 63). In the routinized work in a delivery ward, one thing follows another according to the normal birthing trajectory, as described in the previous chapter. When the baby is born, one of the midwife's tasks was to estimate the health of the baby and conduct the aftercare by examining the placenta and sewing ruptures that might have appeared in and around the woman's vagina. Hence, the routinized demands of midwifery reminded the students of the importance of control and helped them concentrate on what to do rather than becoming too affected by the birth.

What the proper emotions are and how they can be negotiated is something that the students must learn. This was discussed in the interview. It took this turn on the students' initiative, although I of course encouraged it. They spoke of their relationships with supervisors, and that they often identified with them during practical training. However, it also became clear that not all supervisors acted in the same way, which again led to questions of the midwife's role in the delivery and why a midwife should not become emotionally affected by birth, as some supervisors were.

- Sarah One of my mentors rejoiced and wept with the parents. But she didn't upstage anyone. Just because you're happy you don't necessarily take something from someone. If I had a baby, I feel that I would want the midwife to be happy for me. It would make me glad since she'd supported me through it.
- Helen Yeah, that she was touched by the moment.
- / ... /
- Ellinor But I don't follow, if tears come into my eyes, that isn't to say that it's because I did something good, is it?
- Helen It's kind of like you've given too much of yourself ... ahem, no, I don't get it either.

Cecilia Maybe it's because you let your feelings show, and therefore you're not professional anymore.

Again, the conversation circled around what the right professional emotions could include, which emotions a midwife could express, but also how much or how little. I interpret their comments as saying that a midwife should show some emotions of joy and not be cold-hearted, but she should not let her feelings loose, with the exception perhaps of the first delivery. A good midwife, as one of the students said, should feel with a patient but not let her feelings take over. Thus, one should show that one is empathetic, or touched, as one of the supervisors did, but only as long as one does not take over the situation from the parents. In other words, a good midwife should be aware of the situation and of how the parents feel; this means that she should be moderately happy when attending births.

What I have shown so far is that midwifery students have to negotiate what the proper feeling norms are. Different feeling norms seem to apply to different stages of their professional life and to different situations, such as normal or complicated births, but maybe also to different persons in the ward. In the second-semester students' discussion it was clear that tears of joy were allowed and even expected from them during the first birth they attended as inexperienced midwifery students. After that, they ought to be able to handle their feelings and be moderately happy when supporting a woman through birth. They needed to control their feelings because there were other things to be done, like the aftercare of mother and child (sewing vaginal ruptures, for example), but also because they should not allow their own feelings to disturb or take over from the parents.

In the last quote above, Sarah touched upon the second aspect of feeling norms during normal birth that I now will discuss. She spoke of how a birthing woman would want the midwife to be happy for her, "since she'd supported" her through the birth. The students often talked about the importance of not taking credit for the birth; this has to do with the understanding of who does the work during labor. Throughout my field work at the midwifery education program, but also when I was in the delivery

ward, I heard midwives and students emphasize that it is the birthing woman who does the job, they as midwives only support the women. This relates to another feeling norm that tells midwives how to be properly proud of their work. As I will show in the following discussion, it is, however, not self-evident what a proper level of pride is.

To be properly proud about one's work

My second example of a feeling norm regarding a midwife's professional attitude is about being proud of one's work in the "right" and professional way. This means basically two things. First, one should always remember that it is the birthing woman who does the job during labor and the midwife is there to help her. Second, a midwife should not accept being singled out as being better than other midwives in supporting births. I will explore these norms through discussions about gaining "the rose of the day".

"The rose of the day" (and "the rod of the day") are common features in local newspapers in Sweden and refer to short paragraphs of "praise and blame" sent in by readers. They could refer to the local authorities, to named individuals, or to someone unknown. The notices have two sections – one with praise, where persons are figuratively given the rose of the day, for example "Many thanks to my kind neighbor who mowed my lawn while I was on vacation", and the other with blame, where persons are figuratively given a flogging, for example "I would like to flog the person who stole my bicycle last Monday night".

A midwife should not earn the "rose of the day", as I learned from a teacher, a midwife in the ward, and from a student whose supervisor had said the same (this was not the same midwife that I had observed). Underlying this claim, I believe, was a feeling norm that a midwife should not be too proud of herself and give herself too much credit for a successful birth. The woman gives birth to the baby, the midwife only does her job, nothing more, and nothing less. Thus, there were, it seemed, sometimes quite strong norms that a midwife should not be thanked. This was a subject that emerged several

times during my field work, both in the ward and among the midwifery students.

For example, during my second field work session in the delivery ward, a year after the first one, the midwife Elisabeth whom I observed told me that she resented grateful behavior amongst patients. We had just returned from visiting two patients in the maternity ward, who had thanked her for her help during their labor the day before. With annoyance, Elisabeth told me that she strongly disapproved of women thanking midwives and saying they could not have done the birth without them. She went on, and argued that instead it was she who should express gratitude to the women for allowing her to be there with them; this was also what she told them when they expressed their gratitude.

As several other midwives emphasized to me, the woman who has given birth should turn her gratitude towards herself, to her own body, for this accomplishment. She was the one who had given birth to the child, not the midwife.

However, whether a midwife should be thanked or not, and in what way, was a subject the midwifery students that I interviewed did not agree upon. I interpret this as a norm – but a sometimes contested one – about a midwife's proper role in birthing. Cecilia showed one side of it by referring to one of her supervisors in a delivery ward, which combines the discussion about becoming affected and being thanked:

Cecilia My supervisor once said this: 'I can't stand it when midwives are affected themselves by a delivery because this is the couple's moment, not yours. You will have your moment when you give birth to your own child. They are the ones having a baby. You didn't deliver it. She had the baby and you supported her, you shouldn't be too proud about it.

When discussing this statement, the midwifery students both agreed and disagreed with the supervisor. They did not object to the idea that the accomplishment was the woman's, but they saw no harm in being happy with

the parents, as long as they were only moderately happy. Sarah expressed it as “isn’t that empathy?” and continued by saying “To feel compassion, I believe, signifies a good midwife, but of course, one shouldn’t be crying”.

However, it became more difficult when issues of gratitude and pride – as in the “rose of the day” – were brought up. After Cecilia had described what her supervisor had said about a midwife’s role during birth, the students continued to discuss how they could relate to the supervisor’s words and their role as midwives.

Helena Did you agree with her?

Cecilia Well, yes, it sounded sensible at the time. ... [S]he [the supervisor] also said that she finds it disturbing when co-workers several times received ‘the rose of the day’ in the newspaper. And I had thought ‘oh, she [the midwife who got “the rose of the day”] must be really good’. But my supervisor meant that then you’ve done something wrong. If the woman says ‘oh, thank you so much, you’ve saved my life’, my supervisor said you should turn this around and tell the woman ‘no, you accomplished this, it’s your body that managed this. Take this with you and be proud of it. I haven’t done anything. You gave birth to your child’. It’s wrong to think ‘I’m so good, I delivered the baby and that’s why I won the rose of the day.’

In Cecilia’s story, the supervisor expressed a feeling norm about being properly proud. First, she emphasized that it is the woman who does the job and that a midwife should not think too highly of her own contribution. Secondly, and related to this, the supervisor criticized colleagues who get “the rose of the day” (and may even be proud of it). From her perspective, they had not done their work properly, they had not followed the feeling norms about how to handle the patients’ feelings of gratitude, namely to cause the patient to be proud of herself. One should definitely not be happy if one earns the rose of the day!

The students had learned the proper way of how to respond to a woman's gratitude, but they had some objections about the supervisor's attitude towards the "rose of the day:"

- Sarah If parents say to me 'thank you for your support' I answer 'yes, but you're the one who carried this through, you did very well'. But the midwife is not to blame if she gains the rose of the day just because the parents feel that she was supportive.
- Cecilia No, but my supervisor said that she certainly never earns the rose of the day.
- Sarah Oh really? [she said sarcastically]
- Ellinor That's because she's cold-hearted.
- Cecilia Well yes, maybe she is.
- Helena I can see what she's saying and I do agree with her, but only to a certain point.
- Cecilia She was very convincing, in everything. And I was inspired by her. But now, with a little distance, I think that maybe she isn't right about everything. But I do find her approach interesting.

Thus, the four students may be well aware of the feeling norms among some midwives, such as Cecilia's supervisor, who looked at getting the rose of the day with disapproval, but it was not something that they necessarily would have objected to. Furthermore, Ellinor's comment implied that Cecilia's supervisor might never get the rose herself because she did not follow the feeling norm of being moderately happy when babies were born, and thus nobody was grateful. She accused her of being cold-hearted. But the others found the supervisor's attitude "interesting" and agreed with her "to a certain point". What this point was, was however not self-evident.

Teachers and students at the midwifery education program often referred to the work of Haldorsdottir and Karlsdottir when they spoke of a midwife's professional attitude. A "good midwife" is defined by Haldorsdottir and Karlsdottir (2011) as someone who is patient-centered. She cares both for the birthing woman and her family, is professionally competent and can

identify risks for mother and child, combines knowledge and experience, and works to empower women through supporting them in childbirth.

One of the norms surrounding midwifery in the education I have studied is that the midwife should make the women feel that it is they that have accomplished the delivery, not the midwife. This is seen as part of midwives' work; they should both support the patients and handle their emotions in a proper way. In their discussions, the midwifery students negotiated how to distinguish what childbirth was to them in comparison to what it meant to the parents. It was a life-changing experience to the couple because it knit them together as a family, and it was only natural that they were grateful that all went well. But helping women to give birth is part of midwives' everyday work. To them it is not a life-changing experience. They are there to assist the woman, who in the midwives' understanding is the one who does the work; this understanding is not necessarily shared by the birthing mothers.

This attitude could be contrasted with what Bolton (2000) shows for gynecology nurses in Britain. Handling patients' emotions was seen by them as something outside the nurses' normal work; it was a gift, and the patients were expected to respond to it by thanking the nurses. In Swedish delivery care, on the other hand, the support work given by midwives is not to be seen as a gift but as part of the job – and therefore a midwife should not expect to be profusely thanked, especially not in the public realm, such as with “the rose of the day”.

The feeling norms about not being overly proud of what one has done and not expecting gratitude from the patients refer to a midwife's relation to the patient, to her professional role, and to her colleagues. The norm seems to be that one should not overemphasize one's own particular importance in the delivery ward; one was part of a team. Midwives work together and one midwife should be able to take over from another when her shift ends. Thus, several midwives are often involved in a delivery and none of them should stand out amongst the others and receive special gratitude.

Discussion

Midwives work under specific conditions. The students' negotiations of professional feeling norms within midwifery are affected by these conditions. Work in delivery care is intimate but impersonal. The encounters between patients and midwives are often short and fast. A midwife may handle two or three patients during the same shift. She takes over and hands over patients to other midwives as the work shift begins and ends, thus one midwife needs to take over from another without difficulties. Midwives ought to be exchangeable and the delivery care must provide a safe environment, not dependent on the personal whims of a midwife. Midwives' work is therefore both standardized and routinized. On the other hand, situations are complex and may evolve in unexpected ways. This means that there is (in addition to rules about factors like the proper medical treatment, how one should be dressed etc.) a need for feeling norms, which are both strict and flexible, about how to handle one's own feelings in the delivery ward.

Thus, handling one's emotions in a proper way is part of the work in carrying out a profession. Studies of caring professions show how midwives, nurses, and doctors learn to handle their feelings by keeping a distance between themselves and the patients (Allen 2001, Bolton 2000, Jonvallen 2010, Rafaeli & Sutton 1987, Savage 2004, Smith & Kleinman 1989). For example, Smith and Kleinman have described how medical students learn to handle unwanted feelings towards patients, both feelings of lust and disgust, by perceiving the patient body as an analytical object or event. In this way, they handled their own feelings towards patients (1989: 57ff). Savage shows in her study how nurses work to create good relations with patients and to gain their trust, but at the same time try to keep a distance between themselves and the patients and not become too emotionally involved in their suffering (2004: 31).

In contrast to these studies, which discuss how to handle negative or uncomfortable feelings, this chapter has looked at how midwives are expected to behave in relation to a situation they describe in positive terms – the normal birth and the birth that ends well. Thus, the student discussions

presented in this chapter relate to norms about the “right” amount of joy and amazement that they should show in such a situation and what pride they should take in their work. I have focused on normal birth because handling normal situations of pregnancy and birth is midwives’ main task and also what the students are first taught to understand and relate to.

This chapter has discussed the professional feeling norms related to situations of normal birth. In using this concept, I was able to analyze several aspects that are not included in Hochschild’s concept of a feeling rule. Norms are normative and idealizing. They refer to how a midwife should usually experience a situation. What this means is not given, but negotiated within a community of professionals. Norms can, of course, be formalized into rules that employees must obey, but this is not the situation discussed here.

In normal birthing situations, a midwife ought to be moderately happy when the babies are born, not too touched, nor too cold-hearted. One exception is the first birth one attends as a midwifery student. During that birth, a midwifery student is expected to perceive birth as a beautiful event, a situation that might move her to tears. She can be emotional this time but thereafter she should try to handle her emotions because of the work she needs to do. She is in the ward in a professional, not a personal role, and she must behave accordingly. It is not her baby being born – and it is not she who, according to the perspective presented to the students, has given birth. She is there to support the woman and do her job in a professional way. Thus, she may feel professionally proud about the work done, but should not expect personal gratitude from the patients.

The fact that these norms existed as something to follow but at the same time were quite vague and also context-dependent in their application was evident in the students’ discussions. They noted the disapproval of their supervisors when the norms were transgressed; one should not cry when there is a complicated delivery or after the first births attended, nor should one expect public and personal gratitude from patients. On the other hand, the students also showed strong feelings towards the feeling norms. They showed that they were aware of them, but were not sure about whether they always needed to follow them. Thus, they sometimes saw the norms as the

ideal, the mark of a good practitioner, sometimes just as the average that one could relate to in different ways, depending on the situation or one's own wishes.

6. Handling emotionally deviant situations

In previous chapters, I introduced the concept of the normal birthing trajectory to analyze how midwifery students understood what to expect from and how to handle the normal birth, both practically and emotionally. I showed how the midwifery students learned to see the patients' bodily and emotional trajectories as parallel and intertwined.

In this chapter I will turn to how second-semester students discussed how to handle situations when patients did not follow the expected emotional trajectory. Not all patients emotionally experience or express the expected, even when their pregnancies and births progress physiologically normally.

My focus in this chapter are the students' attempts to categorize and predict if a birth will be normal or not from an emotional point of view. Åsa Mäkitalo (2012) has analyzed *categorization practices* in professional groups. She uses this term to understand how professionals handle challenges at work. In working life, problems often emerge that need to be categorized in relation to something the practitioners already know how to handle. This helps them solve the problems they encounter and continue with their work in the proper, professional way:

To categorise problems and tasks, for instance, is a matter of professional judgment and a constitutive element of professional knowing and action /.../ Learning how to categorise 'a case' and what consequences that follow from such action is accordingly crucial to become recognized and sustain oneself as a professional. (Mäkitalo 2012: 60)

Hence, to categorize – or diagnose – is what professionals do to carry out their work. The categories are collective understandings of how to recognize

different kind of situations and how to handle them correctly; this means that practitioners within an occupation normally categorize in a similar way.

Midwifery is no exception to this. In the work in delivery wards, midwives continuously carry out categorization practices. While Mäkitalo describes how working practitioners sort problems into categories that they already know and have worked with, in this chapter I will explore how students negotiated which categories are important to learn and to use, what may be included in a category, and how to recognize and handle a deviation. These discussions took place in courses on complicated pregnancy and childbirth that were introduced during the second semester. Significant for this semester was also that both teachers and students spoke much more about the social encounter with the patient than during the first semester, when they mainly focused on how to examine women's bodies and on physiological aspects of the normal birthing trajectory. My focus is on patients and situations which – for social or emotional reasons – may depart from the desired normal birthing trajectory.

Anna – the psychosocial-risk patient

The following case problem was discussed at two collaborative group sessions during the “Complicated pregnancies and childbirths” course. It was used as an example of the session's theme, “Psychological- and social-risk pregnancies,” which focused on the social and emotional factors that may complicate pregnancies and births. The patient, Anna, was presented as an example of a psychosocial-risk patient:

Anna is single and unemployed. She is an older first-time mother, thirty-nine years old, and she has previously had three abortions. Her relationship with the baby's father is poor. She has moved many times, been through several crises in her life during which she suffered from anxiety and depression, and during one period she also abused alcohol.

Anna believes that she has always been terrified of the labor process because her mother had a difficult one when she gave birth to Anna. It is hard for her to express what it is about birth that frightens her.

Anna is not feeling physically well during the pregnancy. She dreams of being happy with the child, but she cannot feel that the fetus is her real child, despite the fact that she senses the baby's movements inside her.

The fictive story about Anna included information about her background and her worries about the child she expected and about the coming birth. Anna is what Jessica Mesman would call “an exemplary patient.” Exemplary patients are found in the medical literature or in experiences told by someone in the group surrounding a patient (Mesman 2005: 58). In other words, Anna exemplifies a patient with a psychosocial-risk pregnancy – a concept used at the midwifery education program to refer to women with psychosocial risk factors in their lives.

Finding predictive markers in the description of Anna

Poor Anna, it seems that nothing goes her way. She is single and out of work, she is also relatively old, fears giving birth, has been depressed and has trouble relating to her unborn child. Obviously, she is not presenting herself as patients usually do. The interesting part here is what the students brought up as relevant criteria for categorization – what I want to call the predictive markers – of such a patient, that is, what they emphasized as problematic factors to be attentive to and thus to deal with in their coming profession as midwives.

The concept *predictive markers* is inspired by Jessica Mesman's *prognostic markers* (2005), which she applies as an analytical tool to understand the different prognoses made by doctors, nurses and parents in a Neonatal Intensive Care Unit (NICU).

By capitalizing on prognostic markers as an analytical category, it becomes possible to widen our understanding of how actors arrive at their prognosis of a child's future. (Mesman 2005: 65)

Mesman describes prognostic markers as

A number of reference points [that] play a major role: other children that serve as an exemplary case, the level of technological support on which the child depends, the use of the NICU space, or the specific pace and rhythm of the care and the treatment provided. (Mesman 2005: 55)

The reference points, or the prognostic markers, constitute a repertoire and what Mesman calls a “style’ of reasoning” (2005: 58).

When talking about midwifery, I use *predictive* markers instead of *prognostic* markers because the latter has a medical connotation that implies that there is some kind of disease involved and that the prognosis is directed towards the course of that disease. Even though the kind of patients presented in this chapter emotionally deviate from a normal birthing trajectory, pregnant women and women in labor are generally not – from a midwifery perspective – perceived as sick.

This said, like prognostic markers, predictive markers are future-oriented. They indicate that it is possible to foresee deviations from a normal birthing trajectory, in which emotional processes run parallel to – and are intertwined with – bodily processes during pregnancy and delivery. In a midwifery student context, predictive markers are examples of possible threats or warning signals which indicate that the birthing woman will not experience birth as women who follow normal birthing trajectories do. During the session about Anna as well as in other situations discussed below, the students negotiated what to be attentive to (the markers), the implications of these markers (what they might lead to – the predictive outcome), and what to do to uphold the normal birthing trajectory.

While Mesman applies prognostic markers as an analytic tool to understand the differences in how doctors, nurses, and parents perceive a

child's prognosis, she also points out that not all nurses and doctors perceive a patient's diagnosis in the same way. The prognosis depends on many things, for instance, how close the nurses have worked with the specific child as well as their individual previous experiences, i.e. their positions in terms of professional category, knowledge, and experience (2005:55). Similarly, the students differed in their analyses and appreciations of what might be a relevant predictive marker, and how to categorize problematic patients and situations. They focused on different aspects of what could be described with Wiener et al.'s term *biography* (1979), that is, characteristics of both the patients and the situation.

How and why Anna deviates from "the normal patient"

In the brainstorming process during the first of the two sessions about Anna, the students wrote down key words that they associated with patients within this category: fear of childbirth, attachment, partner, addiction, relapse, anxiety, state of depression, social inadequacy, crisis, support, and the resources such as Aurora¹⁹ to help women, counselors, and when to contact the social services. These aspects were brought up as being relevant to characterize a woman with psychosocial risk factors for a possible problematic delivery and to discuss how they as midwives could help her.

The category of psychosocial-risk patient turned out to be more diverse than what was represented in the case problem about Anna. The second-semester students exemplified psychosocial risk factors by mentioning alcohol abuse, depression, being exposed to violence, being alone in a country without relatives and/or not knowing the Swedish language. One of the teachers also made the category a bit more complex by pointing out during a lecture that, for example, if a woman has been a victim of violence, this does

¹⁹ Aurora is a midwifery clinic that specializes in helping women who need supplementary support during their pregnancy, if they for example experience extensive fear of labor.

not necessarily lead to psychosocial illness. But, she underlined, it is a risk factor to be observant of.

Thus, patients' social situations and feelings were acknowledged as important and potentially complicating matters that midwives must include in their work, together with medical factors that involve risks to the pregnant woman and her child, such as diabetes and preeclampsia.

I interpret the brainstorming as a listing of *potential* predictive markers, which referred to the patient's situation but also to the midwife's role. They are, as Mesman (2005) points out, relevant to the actors. For the information about Anna to be relevant, and thus be included as predictive markers of a psychosocial-risk patient, the students must have a plausible explanation of why the information is significant for an encounter with this type of patient. Hence, not all information about Anna that the students brought up during the brainstorming session was acknowledged as predictive markers. The brainstorming also partly went beyond the case to include concepts and words that the students associated with how to encounter women with a deviating social and emotional biography. The teacher present²⁰ during this session encouraged the students to think in terms of concepts that they had worked with during their education; thus the students included concepts such as *support* and *crisis* to focus on. Linking the case problem to the course plan about complicated pregnancies and births reinforced the understanding of Anna as an example of a patient whose psychosocial situation and feelings made her problematic.

²⁰ As I have written previously, teachers were not always present during the collaborative group sessions. A teacher was present in all collaborative group sessions the first semester while the students learned how to work according to PBL, the pedagogical method applied. During the second semester a teacher often attended the sessions but this occurred less often during the third and final semester. I do not know on which grounds teachers decided when to participate in a session. For instance, a teacher was present in one of the sessions where Anna was discussed but not in the other. Because teachers taught third- and first-semester students during the same semester, that probably influenced their absence during many of the third-semester students' collaborative group sessions.

A week after the first session about Anna and psychosocial-risk pregnancies, the students gathered again to discuss the case problem and the questions that they had formulated around the case. The questions revolved around how psychosocial risk factors might affect the mother and the child as well as how to handle such a patient and the different kinds of support that a midwife can offer. During the discussions, the students struggled with why the case problem depicted Anna in this way, what the information implied, and in which ways (if any) the information was relevant. They only spoke about Anna and gave no examples of their own or of similar patients that they had met during their practical training. Anna was a fictive example but it seems she could still serve as an exemplary psychosocial-risk patient and a reference point for what the students thought they might meet in their future profession.

The following excerpts from the students' discussion show how they tried to make sense of the description of Anna. The first excerpt concerns how her age might matter in terms of psychosocial risk.

Johanna I'm thinking about today's case and that she is an older first-time mother. I read in some book, I can't remember which one, that women who choose to have children later in life are used to living according to their own wants and needs. You know, she is used to spending time and energy on herself and what she wants to engage in – attending courses, work, or travel. And then she is suddenly sharing her life with another individual. This can be difficult for her and cause a psychological reaction, and thus be the reason for her not feeling related to the child.

Because age is mentioned in the case, the students inferred that it was relevant for some reason. The case was probably written by an expert on midwifery, and patients in case reports are often reduced to symptoms. Thus, it is understandable that the students expected there to be an underlying aspect to age as something significant and causing problems for this type of patient.

Even though Johanna explicitly talked about the case, the explanation she had found for why age might matter was not really relevant to Anna, who presumably did not attend courses²¹ or travel a lot. These are activities more likely carried out by someone with a more privileged livelihood situation. What the age category marked as relevant and how it affected Anna's future did not make sense, and thus remained unclear. It is possible that age was meant to indicate something special in a psychosocial-risk patient and not just that she was an older first-time mother. But this group of students did not find a useful explanation as to why age mattered in a patient like Anna. Instead, they continued with other potential problems and categories:

- Sarah You can see that there is a potential risk for complications, especially since she has a history of addiction. If she experiences severe stress now and fears the coming delivery, one might assume that there is an immediate risk that she will turn to alcohol to calm herself down.
- Johanna And there is also the fact that her mother experienced a difficult delivery. One of the phases one goes through [during pregnancy] deals with the mother's experiences and one's childhood; it's part of the process.

That is, the students elucidated parts of the case problem about Anna – her alcohol abuse and the stories that Anna had heard about her own birth – in terms of a biography, and explained how they could be complicating factors that affected her birthing trajectory. Johanna pointed out that pregnant women are affected by their childhood experiences, and that Anna was troubled by hers. The implication is that if Anna deviates from the emotional trajectory and does not deal with what she has been told about her own birth, her fear might increase, which in turn might make her relapse into alcohol abuse. In other words, the students turned parts of Anna's biography into

²¹ To attend a course (Swedish: "gå en kurs") commonly refers to evening courses in for example painting, music, language, pottery, or cooking.

predictive markers, reference points that indicate complicating matters. Severe stress in Anna's case might lead to a relapse into abuse. The stress could come from either extensive fear or from not being able to handle the stories told about her own birth and childhood.

Another of Anna's problems was that she could not relate to her unborn child. The midwifery students had learned that how a pregnant woman connects with her child differs through the trimesters and the phases she goes through. At lectures as well as in the literature used, pregnant and birthing women were described as typically experiencing a certain variety of emotions towards their changing bodies and to the babies growing inside them (Faxelid et al. 2001:124ff). As these phases are described, during the first trimester, the woman often has trouble realizing that she is pregnant. This however changes during the second trimester when she starts to feel the baby's movements inside her. To think of oneself and the baby as separate characterizes the final phase of pregnancy and the woman's thoughts are then largely occupied by the coming birth, feeling both expectations and some worries (Faxelid et al. 2001: 124ff). In comparison with how the emotional trajectory is described in the midwifery literature, Anna's emotional experiences and expressions deviate considerably. She is so far along in her pregnancy that she can feel the baby's movements – so she must be well into her second trimester – but, more like a newly pregnant woman, she cannot relate to the baby she is carrying. She is not happy and her fears about the coming birth exceed what is seen as normal worries.

While the case problem presented the patient as one with several potential risk factors, the students spoke of one problem at a time – the fact that Anna is an older first-time mother, a patient with previous alcohol-related problems, and one with problems related to how her mother spoke of her delivery. The psychosocial-risk patient became in the students' discussion someone who could have one or several problems from a list.

The students did have a problem figuring out what to focus on if they encountered a patient like Anna, with a list of problems and potential predictive markers. This made the students question the case problem:

- Louise I don't really get what the case problem is about. I mean, what's the problem? Is it the fear of labor or the social situation? I don't know.
- Camilla It's probably a combination of the two.
- Cecilia Maybe it's like that in reality.

In this exchange the students ceased to discuss Anna as a patient and tried to find more general predictive markers that might lead to complications. When Louise changed the focus of the discussion to how Anna was depicted in the case, she questioned her as an exemplary patient; she did not see what Anna was an example of. As students, they were used to clear-cut descriptions of patients and diagnoses; they were also used to having simplified examples, as a way of learning only one or a few new things at a time. Camilla suggested that the case problem about Anna was more complex, that there was more than one complicating matter that they needed to be attentive to. Cecilia reminded the other students that the case problem was not merely a description of an invented patient called Anna, but suggested that Anna's complex biography might be similar to those of other women that they as midwives would encounter in midwifery clinics and in delivery wards.

The students did not discuss all information available about Anna, and they questioned and problematized some of it. Unlike the attempt to explain why age might matter, none of the students mentioned the patient's abortions or moving around, or tried to explain or question why these were characteristics of a psychosocial-risk patient. One interpretation of this silence could be that the students already knew what this meant and accepted them as criteria of how to categorize a woman as one with a risk for a psychosocial-risk pregnancy. Another, more plausible explanation could be that the students simply did not recognize them as important or relevant predictive markers in their understanding of the psychosocial-risk patient. Hence, assuming that a case problem does not contain irrelevant information, there was a discrepancy between what the course literature presented as relevant information in the patient's history and what the midwifery students included in their discussion. As Mesman describes prognostic markers,

Prognostic knowledge is not simply waiting out there to become applied in practice, but is constituted in the very same practice as it is used. (Mesman 2005: 52)

The psychosocial-risk patient appears as an established category in the midwifery education. However, the students did question why a certain biography was presented as typical of such patients. The various pieces of information about Anna could in certain situations perhaps be predictive markers for a socially and emotionally deviant patient. But the students did not accept them all unquestioningly, nor did they understand all of them. Together they negotiated and problematized what might be relevant and typical markers to categorize and recognize a psychosocial-risk patient.

While Anna's case was a less than clear one of someone experiencing and expressing feelings that threatened to deviate from the normal birthing trajectory, other patient categories were depicted as more obvious problem cases. How the patients would react and how they should be treated by the midwife was therefore easier to predict. I will analyze two such pre-categorized patients – the patient “carrying emotional baggage” and the so-called Aurora patient – before discussing an emotionally difficult birthing trajectory where no established predictive markers seemed to apply.

Patients “carrying emotional baggage”

All midwives, teachers, and students whom I met during my field study seemed to know what a patient “carrying emotional baggage” implied. Emotional baggage is an everyday expression, but at the midwifery education program it was used as a metaphor to talk about patients who carried with them previous traumatic experiences that might influence the delivery. It could refer to complications during earlier pregnancies and childbirths that might affect the woman so that she feared the coming delivery, but also to

experiences of traumatic situations such as sexual assault. Hence, it is not just any kind of baggage of personal experiences.²²

Midwives in the delivery ward took into account patient's emotional baggage, both when speaking with each other and when speaking to patients. During one of my visits, for example, when the coordinating midwife (the shift leader) briefed the midwife whom I observed about a patient coming in for an induced labor she said: "The patient is really worried and has got a lot of baggage, but she seems calm". It was the couple's third child that was about to be born and the woman had experienced the previous births as traumatic. She felt that she had lost control and did not want another birth ending with the help of a vacuum extractor. When the coordinating midwife mentioned that the woman had baggage and also that she appeared to be calm despite her baggage, she indicated that emotional baggage was a useful predictive marker in the community of midwives.

This kind of emotional baggage was not explicitly discussed in a special session in the educational program. It was, nevertheless, a category that teachers and students often referred to when talking about patients with certain experiences. Patients' previous experiences in terms of baggage were relevant to them as predictive markers; they were seen as something that might influence the birthing trajectory and the patients' experience.

In the midwifery education program, the metaphor facilitated sharing experiences in two ways. First, the students could avoid revealing too much information about a patient or a situation that they had encountered during practical training, and thus maintain confidentiality. For example, one of the second-semester students shared an experience with the rest of the class during a lecture. She began her story like this: "A woman came into the delivery ward, and she had this huge backpack with her." Given the context and how the story evolved it was clear that the student talked about emotional baggage based on previous experience that the patient carried with her. It

²² Teachers during my initial interviews, as well as during lectures, also talked about their own, as well as the students' baggage as something that everyone carries with them, and that might affect them in performing their work.

seemed to be a shared understanding among the students and the teacher what the baggage, or in this case backpack, contained.

Second, the point of the story was not *what* the woman carried in her baggage; it was about how the midwife or the midwifery student, knowing about the backpack, *should approach her*. Thus, midwives and midwifery students seemed to agree that one should acknowledge the emotional baggage that patients might carry with them, but not further explore what the baggage might contain; it may not even have a clear connection to the upcoming birth. For example, a midwife in the delivery ward where I spent a few days told a patient, “I have read your medical chart and I am familiar with your history.” Thus, she dealt with the patient’s problematic biography through acknowledging it but not talking about it. Perhaps she wanted to show the patient that she had taken the time to read her chart as a way to reassure the patient and ease her worries, just like the smiles of flight attendants that Hochschild describes as reassuring airline passengers that everything is in order, on time, and safe ([1983] 2012: 4).

Being sensitive to patients’ previous experiences and feelings, to their “emotional baggage” is something midwifery students accentuated as being very important. They considered it part of their professional responsibility to assess the woman’s feelings and ensure that she would get a positive emotional birthing trajectory, despite the baggage that she might have brought with her. However, in the delivery room, there may not only be midwives. Other occupational groups, most importantly medical doctors, may see a situation differently.

The following excerpt comes from a collaborative group session with second-semester students. It shows the students’ view of the importance of taking a patient’s emotional baggage into consideration and how it clashed with how doctors handled a situation. Johanna told a story from her training in a delivery ward. The doctors were called because a patient’s placenta was not expelled within what was seen as a reasonable time. When the placenta does not separate from the uterine wall, or parts of it are retained, this can lead to severe problems for the mother, for example extensive bleeding. In this case, the doctors tried to remove the placenta manually, which meant

that one of them went in with his/her hand through the patient's vagina and manually tried to detach the placenta from the uterine wall. This was done, Johanna told the group, without consideration for the patient's heavy emotional baggage, and it evolved into a traumatic situation for the patient:

Johanna Two doctors pulled like crazy in this girl who had previously been subject to some terrible things. And the doctors had not read her medical records so they didn't know! She panicked and I wasn't able to reach out to her. I stood right next to her, but I lost contact with her and thought 'God, she's going to pass out', I mean, she wasn't reachable at all. And they pulled and they dragged. I can understand why they did it but they didn't inform her, not at first. And that procedure really, really hurts. They [the doctors] were so stressed out and said that they had to take her to surgery. But before the patient was sedated she kept saying 'this is a nightmare' and when she woke up she asked 'did I have my baby?' and 'what's going on?' Since so many horrible things had been done to her, I can only imagine what she thought was going on when they pulled on her like that. When things like this happen, you think 'Why didn't they take her up to surgery immediately and put her under anesthesia?' It is a risk, of course it is. But where is the limit for how you can treat someone?

To Johanna, the doctors' decision to try to remove the placenta manually while the patient was awake was a questionable treatment of a patient with a heavy emotional baggage. From the midwifery student's perspective, the doctors had made this decision because they had no knowledge of the patient's emotional luggage, her biography.

I would argue that midwives and doctors assess this kind of situation differently also because they are trained in different professions, have different responsibilities, and do not have the same access to information about patients. A midwife is responsible for the whole birthing trajectory,

while a doctor participates only in limited parts of it. When the midwifery students discussed this case, they argued that the patient's previous experiences and emotional distress motivated bringing her directly to the operation table. Making her go through the experience of trying to expel the placenta manually while she was awake was to them a larger risk than using anesthesia. It was also a question of their responsibility for the patient's feelings, for responding to her emotional baggage as a predictive marker. As Johanna said: "Sometimes I feel that it is hard to uphold integrity and autonomy in emergency situations. But I also feel that doctors sometimes push it to the limit."

To the midwifery students, there would be a further risk, too. If this patient were to become pregnant again, she would probably want a planned caesarean section due to this traumatic emotional experience. But in Swedish healthcare caesarean sections are spoken of as involving higher risks than vaginal births, something that the students talked about as an unwanted future effect of what the doctors had done. To them, vaginal birth was the normal and desired way of delivering a child.

The doctors, on the other hand, focused on the immediate risks, not on the patient's biography, nor on her future. In this particular situation and from a medical point of view, they saw it as a greater risk to put the patient under anesthesia than to remove the placenta while she was awake. This does not mean that doctors do not care about the patients' emotions, but they interpreted the situation and their responsibility differently. Mesman shows a similar situation in her study where nurses and doctors working in a Neonatal Intensive Care Unit have different perspectives about how long the treatment of a premature baby can go on. The nurses referred to the baby's suffering and criticized doctors "who do not know when to stop". The doctors, on the other hand, referred to other successful cases with babies in similar conditions and thus felt that there still was a chance (Mesman 2005: 53). Consequently, their separate roles and access to information may lead to different understandings of a situation and opposing views of how best to predict what a patient will experience, and how to handle a difficult situation.

The Aurora patient

In the midwifery education program, students and teachers assumed that all pregnant women feel some anxiety about the birth. But they separated such normal fear of the birth from extensive fear, which is what is experienced by the so-called Aurora patient.

An Aurora patient is a pregnant woman whose feelings deviate from the normal emotional trajectory in that she experiences extensive fear of birthing, and will receive special support from specially trained midwives, doctors, and/or psychologists to help her deal with that fear (*The Swedish Society of Obstetrics and Gynecology* 2004: 25). Much like the psychosocial-risk patient or a patient carrying emotional baggage, the Aurora patient was a well-known concept at the midwifery program.

This exemplary patient is not defined in relation to her social situation and not necessarily in relation to any “baggage” of previous traumatic experience, but in relation to the extra support she is seen to need to be able to go through a vaginal delivery. Simply speaking, midwives and doctors either help the woman to overcome her worst fears of a vaginal birth, or decide to deliver the baby with a caesarean section and thus avoid the cause of her fear (the vaginal birth). As a predictive marker, being an Aurora patient indicates that a woman’s fear of birth is so severe that it may not be possible for her to go through a “normal birth”. But the aim is to deal with her feelings in a way that the normal birthing trajectory can be upheld. Thus, much work with an Aurora patient is done before she comes to the delivery ward, both in relation to the pregnancy and to her feelings towards the coming birth.

During a collaborative group session, the students talked about how to define and recognize excessive childbirth fear with the help of definitions in a report by *The Swedish Society of Obstetrics and Gynecology* (2004). The students thus learned to categorize fear, depending both on how the woman expressed her fear and at what it was directed. They learned to differentiate between a first-time mother who is afraid of something that she has not experienced before, and a woman who is scared because of previous traumatic birth experiences. They also learned that the fear could be further categorized

according to the extent of it, i.e. the intensity of her fear and for how long she has carried these feelings with her. When a teacher spoke about possible causes of childbirth fear during a lecture, she listed the following aspects of what such women's fears are directed towards: the progress of the birth, not being able to handle the birth or the baby, the pain, losing control, dying, or medical intervention. Other reasons mentioned were that the personnel in the delivery ward might be unkind, leave them alone, or not include them or inform them of what would be happening. Hence, women's fears can be directed towards several different aspects of the birthing process.

Thus, the students were provided with a repertoire of predictive markers which may categorize the patient as an Aurora patient and thus what they ought to be attentive to when encountering women who express fear towards birth. However, both students and teachers also problematized what it meant to become an Aurora patient and how that might affect the woman. Not all childbirth fear should lead to such a categorization, they argued, but other measures could be taken instead. As one of the students said "Don't you think that it's [too] easy to immediately send them to Aurora instead of scheduling two extra appointments [to see the midwife at the midwifery clinic]?" Also the teacher questioned this categorization during a lecture, asking the students how becoming an Aurora patient may affect a woman's fear. The students then discussed whether it might even increase the woman's fear to be categorized as someone who needed that kind of support. Their conclusion was that if the fear could be handled by an additional visit to the ordinary midwife, these women could remain "normal patients" and not be singled out as Aurora patients in need of special support. Thus, what they seemed to imply was that becoming an Aurora patient might make the women feel marginalized.

Nobody questioned the vaginal birth as the ideal, not even for the Aurora patients. The following excerpts come from a collaborative group session with second-semester students. They had recently come back from practical training in wards and talked about their experience:

Louise We had an Aurora patient. A caesarean section was planned but they wanted to see if inducing labor might work. It was mainly my supervisor who took care of the patient. She [the patient] was very scared. But I thought that my supervisor did some concrete things that helped her, she said: ‘Yes, this hurts but it will not harm you. It is painful but it’s not dangerous.’ She said that all the time and I felt that it was exactly what she [the patient] needed to hear. And the pain isn’t dangerous. The whole labor went well. This is the kind of thing you can’t learn through studying.

This excerpt elucidates three interesting aspects about encountering Aurora patients. First, the vaginal birth remains the ideal, even though a caesarean section already has been planned. Second, it shows how to work with the patient’s feelings, and third, it says something about how that kind of work affects the midwife.

Louise spoke of managing the patients’ feelings as a way of upholding the normal birthing trajectory. In this case, it was known beforehand that the patient suffered from extensive fear of pain, a predictive marker for this type of patient that threatened to complicate the birth. Her feelings of fear had brought about the decision of a planned caesarean section, a decision made by a doctor. In this case, however, the doctor decided to try induced labor, which implies that vaginal birth is preferred despite the patient’s fears. It also implies that with a midwife’s support and a planned and medically controlled vaginal birth, it is also possible to handle an Aurora patient’s emotions and to enable her to have a vaginal birth. There was a constant uncertainty about whether or not it will succeed – but “the whole labor went well,” as Louise said, presumably meaning that it ended with a vaginal birth. Although the patient had expressed extensive fear, the midwife managed to handle her feelings in a way that they did not jeopardize a normal birth.

When patients are more emotionally demanding than others, it affects the midwives, as well. Working with patients who are very scared of the birth was something the students discussed as hard work:

Sarah I met many Aurora patients during this last period [of practical training in a delivery ward] and many of them had some kind of psychological diagnosis in their past. And it is a really demanding task to work with those patients. ... I think that change of staff [between work shifts] is good for everyone.

This excerpt comes from a collaborative group session during the course about complicated pregnancies and childbirths. Aurora patients were mentioned or discussed during several of such sessions and at lectures during the second semester. None of the stories mentioned how the women had experienced the situation; the stories were about the students' experience of meeting such patients. It was emotionally tiring, and a relief to be replaced by someone from the next work shift; that was "good for everyone".

Patients who become panicked for no predictable reason

I have shown how students discussed different types of exemplary patients whose feelings and previous experiences threatened a normal birth. The students had learned a collective understanding of how to recognize and categorize patients whose feelings deviated from the normal birthing trajectory and how to handle encounters with them. But the students also talked about other, seemingly "normal" patients, who were not categorized as Aurora patients, nor shared any of the other predictive markers for a difficult birth – but who suddenly panicked in the birthing situation. This implied an imminent risk that the birth would become complicated instead of following the normal birthing trajectory.

The following excerpt comes from a collaborative group session with second-semester students, who discussed complicated childbirths, such as drawn-out deliveries and severe bleedings. The students' discussion included stories of what they had experienced during practical training and of how to deal with patients who were seen as different from ordinary patients. One of

students told the following story from her practical training in a delivery ward:

Camilla I had a patient who was the most hysterical person I have ever met. I was scared. She was like a monster. She threw a pillow at me and screamed right out. Her mouth was wide-open and panic distorted her face. It ended in a caesarean section. I mean, it was crazy. I thought ‘she’s going to kill me’. She was hysterical!

It is likely that the student did not really fear for her life but used the expression to emphasize the intensity of the patient’s feelings. As it seemed, it was not until the woman was in active labor that her feelings deviated from the normal emotional trajectory. Her panic led to a decision to do a caesarean section, which meant that what seemed to be on the trajectory towards a normal vaginal birth ended in a surgical operation. The patient’s uncontrolled emotions turned a normal birth into a complicated one.

Camilla’s story did not reveal anything about the patient’s past that might have led her to become so hysterical that the birth had to end in a caesarean section. There were no obvious predictive markers. The students nevertheless tried to find reasons for why patients would be this panicked as a way to foresee and manage the patient’s feelings, to possibly avoid surgery, and thus to uphold the norm of the normal birthing trajectory. They started out by discussing pain as a possible reason, offering narratives of what seemed to be similar situations to the one experienced by Camilla:

Johanna One patient we had [Johanna and her supervisor] acted as if she [i.e. her cervix] had been dilated nine centimeters, but it was actually only three.

Selma I know how it is, I have had three patients like that.

In Johanna’s example the patient’s experience of pain far exceeded how women were expected to feel during the early phase of delivery. When a

patient is only dilated three centimeters (the lower limit for active labor), she should not report as much pain as when her cervix is dilated nine centimeters and she is closer to birth. Selma had also encountered patients whose experience of pain she estimated as excessive in relation to the stage in the normal trajectory and thus, one may infer, were difficult to predict.

Camilla's classmates also suggested that the woman may have panicked because certain positions of the baby cause immense pain that might have become unbearable to her. But Camilla dismissed the explanation that the patient's reactions had something to do with the baby's position. "She was only scared, and she panicked", she said.

As physical pain was not the reason, the students continued to search for other predictive markers for what may cause patients to panic in the delivery room. This, of course had a bearing on what they as midwives should expect and how they should handle the situation. Communication problems were mentioned:

Selma Did she speak Swedish?

Camilla Oh yes.

Selma We had a patient who didn't speak Swedish. She hit herself with pillows and with the laughing-gas mask. I panicked, and I was alone in the room with the woman. There was no midwife or anyone else around, because they were all busy elsewhere.

Selma's story is quite similar to the situation that Camilla described. Both talked about patients who panicked in the delivery room and about the students' feeling of helplessness in a situation that they had not foreseen. In Selma's case, the communication problem may have increased her sense of not being able to reach out to the woman and help her calm down.

The students had a number of predictive markers for panicking women in their repertoire – the baby in a disadvantageous position that might increase the pain, or the birthing woman and the midwife being unable to communicate – but they could not find any of them in the story told by

Camilla. The birthing woman's feelings went astray without the possibility of prediction. Thus, the students were at a loss as to how to help such women.

Johanna Well, in these situations, you just have to try to calm them down. One can see how important this is, if they feel that they are in a calm place and feel safe.

Camilla So, it must have been my support that was not good enough [she said in an ironic voice, and made everyone burst into laughter].

Johanna spoke about how to handle these kinds of situations in general terms; as midwives they should be supportive when women panic, and preferably create a calm and safe atmosphere so that women do not panic at all. Camilla ironically remarked that perhaps her support had not been enough; but she was reinforced by the others saying that their support is not always enough to calm these women down. Such a situation is not easy to handle and the students did not yet feel confident about what to do when patients' fears took the upper hand. When Selma said that she panicked it was because she was in the room all by herself without an experienced midwife; she defined herself as a student who could not yet handle such situations. Johanna agreed:

Johanna It is tough on you in those situations, you have to be there and watch them. I've also been there when patients have become panicked. They are so scared and I think it's scary to see that.

The stories told by the students gave examples of women with the "wrong" feelings, or too intense feelings, where it might not be possible to go through with a normal birth. Even if a midwife had initially categorized a pregnancy and childbirth as normal and the patient had no known emotional baggage, sudden emotions could affect the birthing situation and complicate it.

The narratives in this chapter of how to predict and encounter women with deviating emotions refer to the midwife's role of how to support these women and also to how the students experienced these encounters. The

patients were described as more demanding than others and the students often felt inadequate in their ability to properly support them and make them feel calm and safe. The students also spoke of themselves being scared and not knowing how to handle the situation. Sociologist Juliet Liand Rayment has described caring for demanding patients as something that causes midwives distress. Midwives often attend more than one patient at a time. Having one patient who needs extra support consequently leads to the other(s) being given less time and support than usual (2011: 166). I rarely heard midwifery students talk about the experience of handling several patients at a time, something that may have to do with them still being students with limited responsibility. However, they still expressed frustration in terms of not being able to properly support the patients with psychosocial and emotional difficulties and help them achieve the ideal of a normal birthing trajectory. Hence, they seemed eager to help these patients whose feelings deviate from the normal birthing trajectory, but they also recognized it as a demanding and sometimes distressing kind of work.

Discussion

Students reacted to these emotionally different patients in several ways. They were different from the “normal patient” that students encountered during the first semester at the midwifery education program. While the first patient discussed here, the psychosocial-risk patient, was presented through a case problem, the others were contributed by the students themselves as examples of topics to be discussed during the collaborative group sessions and during lectures. A patient’s social life or medical history were included in the students’ discussions in those cases where the students had learned that it could affect the pregnancy and birth, the woman’s experience of it, or how the midwife should approach her.

I have applied the predictive marker concept to explore what the midwifery students emphasized as reference points in their discussion about different types of patients and how they negotiated in what ways these could affect the birthing process and their own approaches towards the patients.

The challenge that the midwifery students discussed was how to prevent a normal labor from becoming complicated, that is, to handle the patients' emotions so that the labor could end with a normal delivery.

When the students discussed how to recognize these patients, for example through a history of depression, or previous experiences such as sexual assault, they negotiated which factors to recognize as predictive markers and of what they were predictive. Furthermore, the students discussed how they as midwives could support the patients towards normal birth and positive birthing experiences (or at least to prevent such terrifying experiences that they would fear another delivery in the future). Handling the patients' feelings meant striving for a normal birth, which is a vaginal birth where normal bodily and emotional trajectories run parallel.

The psychosocial-risk patient, the patient carrying emotional baggage, and the Aurora patient were depicted as three different types of exemplary patients whose feelings did not follow the normal pregnancy or birthing trajectories. The fourth type of patient, the panicked woman, was spoken of as a category for which the students could not find any useful criteria or predictive markers.

How the students tried to make sense of these patients and how they were depicted in the case descriptions was, in a sense, based on quite meager information. This is, however, not unlike the situation in the ward. Working in delivery care means that a midwife often meets different patients each work shift and thus has to make predictions based on what little she can learn about the patient's previous experiences and her livelihood situation, i.e. her biography, which might affect her feelings during the labor process.

What this chapter depicts is that there are also norms about the complicated birth, which may help the students prepare for working life. They cannot foresee or practice on an extensive range of different patients they might encounter. Finding predictive markers and exemplary patients may help them categorize the situations they encounter and help them deal with them. They negotiated how to understand how patients with what was seen as deviating emotions usually feel and act, and what biographies they might have. The intention was to help them handle their fear, but also, it

seems, for them to help these women accomplish the norm of a normal birthing trajectory, that is, the vaginal birth and not a caesarean section (planned or emergency).

7. The good and normal pain²³

Giving birth is painful, and thus working as a midwife in a delivery ward means working with women in pain. This chapter focuses on midwives' understanding of childbirth pain as part of the normal birthing trajectory. I argue that, from a midwifery perspective, pain during labor is seen as necessary, that it ought to be there for the birth to be normal, and that it is productive because it is understood to be bringing the birth forward. However, some pain may exceed the limits of the good and the normal and must be recognized as such. Thus, students need to learn how to estimate the level of pain, to recognize when the pain is not normal, and to estimate how to handle pain to make sure that a labor follows the normal trajectory.

A normal and manageable pain

Research on pain in the social sciences often concerns suffering. It discusses issues such as chronic pain and stigmatization (Jackson 2005), the interdependency between pain and drug use (Connors 1994), or distress expressed through physical pain (Trnka 2007). In a midwifery context, the focus, however, is not on suffering, but on pain as something positive and productive.

Just as being pregnant and giving birth is seen as something *normal* in midwifery education, physical pain is considered to be a normal part of the

²³ This is a revised version of an article previously published in an interdisciplinary anthology about dimensions of pain (Folkmarsson Käll (ed.) 2013), based on a conference held by the Gender Body & Health network. In that article, I used material from my first days of observation in a delivery ward and material from a Swedish Television documentary called "Barnmorskorna" ("The Midwives") (produced in 2007, aired in 2008) which depicted midwives' work in a delivery ward in Sweden.

birthing trajectory. “It’s not about pain or no pain – the pain should be manageable”, a teacher said during a lecture on normal pregnancy and childbirth. She continued, “Do not ever feel sorry for the women, but be empathetic with them”.

Several norms about normal pain can be elucidated from her words: pain is a normal part of labor, normal pain can be handled by the birthing woman, and the midwife should show empathy but not feel sorry for the patient and her pain.

This midwifery approach to pain during labor is something that the students have to learn, as it is different from the attitudes they held before. One of the requirements for attending a midwifery education program in Sweden is having worked full time as a nurse for twelve months. When training to become midwives, the students not only leave behind them their old work identity as nurses. They also change their (nurses’) view of pain as a symptom of a disease and something that must be alleviated, to one that sees pain as something normal. Labor pain, they learn, is not dangerous and thus is nothing to be afraid of. This requires a different attitude towards the patient and towards how to handle pain.

One characteristic of labor pain, which distinguishes it from other kinds of pain and which students were taught about, is its temporality. Labor pain comes and goes with the contractions. When a labor progresses normally, there are always pauses between the contractions and thus periods without pain. Furthermore, the pain should be there because, as the teacher explained during the lecture, it brings the delivery forward and leads to something good – the birth of a baby.

First-semester students were taught the physiological specificities about this kind of pain. During their collaborative group sessions they focused on where the pain is located and what in the delivery process may cause the pain. They talked about where the pain originates during different stages of the delivery and how it changes along with the labor process. This discussion referred only to physiological aspects of birth, and focused on questions that the students themselves raised during the discussion, such as: “The

contraction begins in the upper part of the uterus, but where is the pain felt?” and “How does the angle of the cervix affect where the pain is located?”²⁴

Another characteristic of labor pain is that it ought to be manageable by the woman. The first-year students experienced in a concrete and firsthand way how this was possible during one of their lectures. They had not been to practical training in delivery wards and thus had not yet attended a birth from a midwifery student’s perspective. Now they were told that if one relaxes, the pain will be less.

The students worked in pairs. Under an experienced midwife’s guidance they performed several exercises inspired by midwife Signe Jansson, who in the 1970s had introduced breathing and relaxation exercises to handle birth and birth pain.²⁵ After having practiced controlled breathing in which the aim was to be as relaxed as possible, the students did a pinching exercise. Working in pairs, one of them was to tense only one arm and try to relax the rest of her body. The other person pinched her tensed arm. In this exercise, the arm stood for the working uterus and the lesson was that it would be easier to handle the pain of the pinching if the rest of the body was relaxed. Emelie, one of the students, suddenly smiled and burst out, “It doesn’t hurt!” Frida, who was pinching her, looked both fascinated and a bit worried. She said that she was pinching Emelie quite hard. Similar comments were heard around the room. Thus, the reaction from the students was amazement. They appeared to be surprised that they, through relaxation, could handle being pinched quite hard.

The exercise seemed to convince these first-semester students that pain was not necessarily that painful – that is, if you were relaxed and in control of your breathing. It contributed to changing their approach to pain from their previous, nurse-related views. In this and other ways, the teachers introduced the concept of normal birthing pain as a manageable pain to them. The

²⁴ The angle of the cervix is described as being either directed towards the woman’s back or her front, but during the labor process it changes so that it angles towards the birth canal (Faxelid et al. 2001: 169).

²⁵ See “Signekursen” by *The Swedish Association of Midwives (Svenska barnmorske-förbundet)* (2004).

students learned that a woman could learn how to handle normal birthing pain through breathing exercises and being relaxed, and thus to experience it as less painful. They also learned that they, as midwives, should support the women by helping them to relax.

However, the view that pain is normal and manageable is not necessarily shared by the birthing women and their partners. For example, a study by Angela Baker et al. shows that there is a discrepancy between the pain that birthing women experience and how the midwives estimate their pain; this has an impact on what they call the “appropriate management of pain” (2001: 171). This means that the pain relief method applied should make the pain manageable to the woman, not take it away.

Midwives work towards sharing their perspective on pain with the birthing women. During a lecture about childbirth pain and non-pharmacological pain relief methods, the teacher told the first-semester students that they should remind the birthing women that they are not dying and that to be in pain is normal. The fact that midwives need to tell women in labor that the pain will not kill them may seem absurd. However, it does say something about midwives’ and birthing women’s different approaches to pain, and the difficulties that the students may encounter when dealing with women in pain.

The following excerpt comes from a collaborative group session with second-semester students. The theme to be discussed was pharmacological pain relief methods. In contrast to the first-semester students, these second-semester students had had experience from delivery wards when they discussed childbirth pain. They were now halfway through their education. The excerpt illustrates how they spoke of midwives’ and birthing women’s different approaches to pain.

Johanna Many of those [the midwives] who work here in the delivery ward say that women’s attitude towards pain has changed. They said that those in our [the students’] generation think that the pain can be eased, that childbirth doesn’t need to be painful. But that’s not right. I mean, being in pain means that

the labor is progressing, it is normal. Today women seem to be afraid of being in pain.

Johanna narrated what other midwives had said about women's attitudes towards pain, where some women fear what midwives consider normal pain. But to Johanna, labor and pain are inseparable and pain is a sign of progression. This difference between midwives' and birthing women's perception of pain was drastically illustrated by another student:

- Cecilia If you say [to a birthing woman] 'Remember that the pain is positive and that it brings the birth forward', she'll say 'Go to hell'. [The other students laughed.] It's because she's in such pain.
- Sarah And when they say 'Oh, I can feel a pressure now' and you say 'Well, that's good!'
- Johanna Yes, that's what we want!
- Sarah And they just... Well, I think you could get smacked. [The students laughed again and they seemed to recognize the situation.]

The students described situations where there was a clear distinction between how they and the birthing women perceived pain. They saw a pressing pain as signifying that the labor was in fact normal and progressing towards the baby being born, whereas the birthing women reacted strongly to the pain and did not seem to agree. The excerpt also indicates that the students now had learned not to fear pain and not to feel sorry for women in pain; these are explicit feeling norms in the midwifery education.

But the students also discussed that the birthing women may not perceive pain and pain relief in the way that midwives want them to:

- Cecilia I read that it would be preferable if midwives during pregnancy check-ups could encourage the attitude of: 'I take whatever

- [pain relief method] I need depending on where I am [in the delivery process]’.
- Sarah Sometimes I feel that the birthing plans might be a bit unrealistic. Especially those written by Aurora patients²⁶ saying ‘I must have this and that’. I mean, it might not be possible.
- Cecilia Exactly, you can’t get an epidural if you’re dilated ten [centimeters].
- Johanna Yes, but at the same time one wants them to feel empowered and that they are in control over their own labor processes.

Thus, the students problematized the discrepancy between the laboring women’s attitude towards pain and pain relief and their own midwifery perspective. They had, as discussed in previous chapters, learned that they should support the women, that the women must feel that they are the ones giving birth, and that they have influence over the delivery’s progress. On the other hand, the students now acknowledged that there are limits to the women’s capacity and possibility to decide about pain. To estimate what the proper pain relief is at different stages of the delivery should, they argue, be the midwife’s professional task.

The professional estimation of pain

What I have shown so far is how midwives regard pain as part of the normal birthing trajectory. Whether or not the labor pain caused by uterine contractions is productive or whether it is too weak or too intense is a matter of midwives’ professional judgment. In every profession there are routines of how to carry out work in a knowledgeable way, which are based on collective knowledge as well as on individual experience. The routines are part of what Stuart Shapiro calls “standards of practice”. These “constitute a representation

²⁶ Women who experience intense fear of labor can see specially trained midwives and doctors to help them deal with their fears of being able to go through a vaginal birth. Aurora is one term for such kind of supportive activities.

of how members of that particular community do or are expected to make decisions and a sense of the nature of appropriate discretion” (1997: 312).

Midwifery students learn as part of learning their profession to estimate the pain experienced by birthing women. In a study of how midwives experience dealing with women in labor pain, Ingela Lundgren and Karin Dahlberg, researchers in healthcare science, discuss midwives’ complex task of estimating pain. The complexity, they argue, arises from having to understand the woman’s subjective experience of pain and align it with the midwife’s professional estimation of the intensity of the pain.

To show respect for the limit of the woman meant that the midwife had a responsibility to ensure that the woman did not exceed the limit of her ability and that the pain did not become too much for the woman. ... To respect the professional limits meant to support the woman’s capacity to see the normal process of childbirth, but also to see the boundaries of complicated childbirth. (Lundgren & Dahlberg 2002: 157)

Thus, Lundgren and Dahlberg emphasize the complex character of what the midwifery students need to learn. They should be able to estimate the woman’s ability to manage pain and try to uphold the norm about a normal birth and at the same time prevent the risks of complicating matters due to excessive pain. Thus, they must be able to estimate the progress of labor and the level of pain experienced by the women, something which is not always easy to do. According to Maureen L Sookhoo and Colin Biott (2002), midwives rely upon established procedures and routines to avoid this uncertainty. In their study of how midwives judge the progress of labor, they write that midwives rely upon procedures such as vaginal exams and the number of centimeters a woman’s cervix is dilated. Midwives have learned that certain ranges of centimeters indicate what stage of the birth she is in, for example 3-4 centimeters for active birth. Hence, these are collective guidelines adopted within midwifery. The vaginal exams continue during the labor process. The figures are inserted into the medical record and help the midwife to correlate the number of centimeters of dilation to the expected

normal pace of progress. But, as Sookhoo and Biott write, the progress of birth is still a matter of judgment. It is also, as I will show, a matter of interpreting signs from both the woman and the technology used.

Two examples from my field work show the importance of how pain is estimated and the significance of a *productive* pain, that is, a pain that is neither too strong and maybe dangerous, nor too weak and not bringing the birthing forward. I observed two different encounters between a midwife and laboring women in the delivery ward.

In the first example, the woman's pain was too weak. She was having her third child and was in the ward for induced labor. The midwife artificially ruptured the membranes to make the water break and gave the woman a hormone-like substance to stimulate her uterine contractions. Induced labor aims to create a situation resembling a normal labor process, even if the water breaks artificially and the contractions are artificially stimulated. The midwife had to estimate whether there were uterine contractions or not, based on what the woman expressed and what was shown by the CTG device.²⁷ The CTG device registered that the woman had contractions – we could see the curves on its monitor – but the woman said she could barely feel any contractions. Thus, the midwife's interference of inducing labor seemed not to have been effective. As the woman was not in pain from the contractions, it implied that they were not strong enough, and as the midwife explained to me, the woman's labor would probably take many hours. Something was going on, but it was not from a midwifery perspective viewed as being productive.

The second example comes from a situation where the midwife estimated the woman's pain as too intense. It concerned a woman having her first child. The pain from her contractions was immense and she did not seem to get enough rest in between them. The midwife said to me that she could tell from just looking at the woman that the contractions were too painful, even though the CTG device measuring the woman's contractions indicated

²⁷ The CTG device (Cardiotocography) measures the baby's heartbeat and the woman's contractions through devices that are attached to the woman's belly with elastic belts.

that they were not that intense. The midwife raised the question of additional analgesics because the nitrous oxide²⁸ did not seem to help, and asked the woman if she would consider a spinal anesthesia. The woman accepted it, and an anesthesiologist was called to administer it. Later, the midwife explained to me that women experience and handle pain in different ways. The pain that this woman was experiencing was too much for her to handle for a longer period of time. Thus, the midwife estimated that her pain exceeded what could be seen as good and normal, and something had to be done.

In both examples, the midwife whom I observed estimated whether the birth was progressing normally or not. She did this based on what the technology indicated, what the woman expressed, and from a midwifery perspective on the intensity of pain in different stages of birth. However, the pain subjectively experienced in the women's bodies differed in both cases from what was shown by the CTC technology. Subjective pain cannot be measured, which means that the midwife had to use her professional judgment to estimate whether the pain was good and normal, or too weak or too strong. In both of these cases, it seemed that the midwife saw the technology as not giving adequate information about the contractions.

Thus, there ought to be pain for the delivery to progress – but not too much pain. Extensive pain, for a long period of time with no breaks, is not considered a good pain, as the woman in labor needs to save some strength for the final part of the delivery when the bearing-down contractions begin. As shown in a previous chapter, there is a risk that the patient will become panicked if the pain is experienced as being too intense. If the midwife is not able to calm the patient down and regain contact with her, a caesarean section may be needed. This may be seen as a failure because it is important both to strive towards a vaginal birth and for the woman to have a positive birthing experience. But the labor should not be pain-free, as that may indicate that the labor process has ceased. A drawn-out delivery could also lead to doctors

²⁸ Nitrous oxide (laughing gas) is used today as pain management in 70% of all deliveries in Sweden. ("Nitrous oxide during labor", *The Health Care Guide*)

deciding to do a caesarean section or to use a vacuum extractor – procedures which deviate from the preferred vaginal birth with limited intervention.

Handling different experiences of pain

Pain has been described by Jean E. Jackson as “an aversive feeling experienced in the body that cannot be measured directly.” (2005: 333). Sara Ahmed, like Jackson, refers to pain as an aversive feeling, but adds that there is more to pain than mere physical experience:

[Pain] as an unpleasant or negative sensation is not simply reducible to sensation: how we experience pain involves the attribution of meaning through experience, as well as associations between different kinds of negative or aversive feelings. So pain is not simply the feeling that corresponds to bodily damage. (Ahmed 2004: 23)

Thus, Ahmed acknowledges that pain is not only a question of a bodily experience arising suddenly; there are also previous experiences and “social and cultural practices” which affect how pain is perceived (Ahmed 2004: 9).²⁹

This insight about the importance of previous experiences was also reflected in the second-semester students’ discussion. They wanted to include the women’s subjective experiences of pain and how they as midwives could support them depending on their culturally defined wants and needs.

Johanna You have to take into consideration the woman’s previous experiences of pain, if she has given birth before and if that birth took place in Sweden. Whether or not she has practiced how to handle the labor pain also matters.

²⁹ Understanding pain as not only a bodily experience, but also a subjective feeling including cultural implications has developed over time in healthcare professions. See for example William Ray Arney and Jane Neill (1982), who from an historical perspective present the work of obstetrics. This work is described as changing along with their perception of labor pain.

Selma There are women from other cultures who are not prepared to get any kind of pain relief. They are so skeptical of it. Even so, you try to explain that you can see how much the pain affects them. But there is nothing to do but to continue asking if they want something for the pain.

Johanna and Selma suggest that women's attitudes to pain might differ depending on where they come from and where they have given birth before, as well as the women's preparation for handling the pain. In the quotes, the students elucidate how the women's previous experiences of birthing affects their midwifery estimation of pain. Pain is not merely a bodily experience, but is also socially and culturally affected. This was also described as affecting the women's attitudes towards pain relief.

In their group discussion, the second-semester students talked about how the *phase of delivery* matters to possible pain relief methods. Johanna explains this further:

Johanna It is very important that we as midwives ask [the woman] where the pain is located, how it feels and how she experiences it.

The midwifery students know that pain differs in different stages of the delivery and thus also the appropriate pain relief methods. The first-semester students had learned how the angle of the cervix affects where the pain is located. Second-semester students also learn the importance, just as Johanna emphasized, of asking the birthing women where they feel the pain. This will influence their decision of what pain-relief methods are to be used in that particular situation. Still, it is a matter of judgment of what is appropriate to do, something which also means that there may be different points of view. This was apparent when the second-semester students discussed giving morphine to women at an early stage of labor:

- Sarah I think that morphine is given way too often to women in the early labor stage.
- Cecilia You do? I've only seen it once.
- Sarah Yes, with first-time mothers who are dilated one or one-and-a-half [centimeters] and who are in such hellish pain. They get morphine and then are sent to the maternity ward to sleep.

Sarah did not agree with the use of morphine given to women at an early stage of labor. It reduces the woman's experience of pain but does not bring the birth forward. However, she had no suggestion of her own on how to support these women who experience intense pain even before being in active birth.

Easing the pain

When the teacher said "It's not about pain or no pain – the pain should be manageable", she not only indicated that labor pain is normal. She also opened up for a perspective that there are limits to pain even in childbirth. Thus, interventions may be needed in order to maintain a normal birthing trajectory, which progresses at a certain pace, ends in a vaginal birth, and results in a positive experience for the woman, with the mother and child in good health.

In research on labor pain, many studies focus on pain-coping methods from a birthing woman's perspective (Abushaikh 2007; Leap et al 2010; McNeil and Jomeen 2010), or on how midwives teach pregnant and birthing women how to handle labor pain through various forms of pain relief (Benfield et al 2010; Iliadou 2009; Yerby 2001). But how are different pain management choices perceived from a midwifery perspective and in which ways can these be seen in relation to norms about normal birth?

Midwifery students learn about several different kinds of pain relief methods that may help the laboring women to handle pain: non-pharmacological methods during the first semester and pharmacological ones during the second semester. Non-pharmacological pain relief methods included encouraging the woman's partner to give her massage, having the

woman take warm baths or hot showers, and the midwife using warm wheat bags to ease the pain. A midwife can inject sterile water into or under the skin in the woman's lower back if pain is felt there. In some delivery wards, patients can get acupuncture. Among the pharmacological pain relief methods discussed by the second-semester students were nitrous oxide, epidural and spinal anesthesia, PCB, PDB, and morphine.³⁰

The following excerpts come from the collaborative group session where second-semester students talked about pharmacological pain relief methods. In this first exchange, the students emphasized the importance of the woman being relaxed and breathing properly, and how that would help her to deal with the pain – just as in the experiment that the first-semester students had undertaken. The excerpt shows how the perception of pain as good and normal also permeated situations where not-so-good and normal pain was discussed.

Johanna	If she is scared she will be tense and it will hurt even more. It is important to be able to relax.
Sarah	To have a good breathing [technique] is so important. Because if you breathe deeply, the body relaxes and being relaxed decreases the sense of pain. I think that just by breathing deeply into the mask makes them [the laboring women] calm down and become more relaxed.
Camilla	It gives a feeling of security, I mean the mask itself. We had a woman who brought the mask with her into the bathroom.

Hence, it may be so that the women's feeling of security is not the physiological effect of the nitrous oxide, but the mask in itself may help the

³⁰ Both epidural and spinal anesthesia are given in the woman's lower back and are administered by an anesthesiologist. PCB and PDB are local anesthesia. PCB is administered by an obstetrician or by a specially trained midwife. It numbs the area around the cervix and eases the pain during the opening stage of labor. A midwife administers a PDB. It numbs the pelvic floor and eases the pain during the expulsion stage of the delivery.

women breathe in a proper way and thus feel safe. The importance of the woman being relaxed was reiterated later on in the discussion:

- Johanna Well, the most important thing is that someone is there with her, someone who is secure. She'll be in less need of pain relief if she feels that she is safe.
- Sarah Yes, because the emotional experiences matter [to how laboring women handle pain].

In these remarks about how to handle labor pain, Johanna and Sarah emphasized the norms about normal birth and about how pain should be experienced and handled by the woman. To be accompanied by a supporting person who helps the woman relax and presumably have a positive attitude towards birth was reiterated as the proper way to approach birth and thus to uphold the normal birthing trajectory.

Sometimes non-pharmacological pain relief methods are needed to facilitate a normal birthing trajectory. The students spoke of analgesics in relation to the progress of birth where one particular pain relief method could be promoted because of its ability to facilitate the progression.

- Selma It [PCB] helps immediately. We had a woman with whom nothing happened for two or three hours. And then she was dilated five or six centimeters in a couple of minutes.

In this story, Selma told of a woman whose birth did not progress according to an expected pace, "nothing happened", she said. The analgesics given in this case were spoken of in terms of achieving a normal birthing trajectory. But pharmacological pain relief was also discussed as involving risk.

- Johanna It [an epidural] doesn't take the pain away, it increases the pain tolerance which means that one can better stand the pain and thus also relax. ... But, the downside is that it [an epidural] will probably prolong the delivery process. And if it is a

prolonged delivery and the woman needs additional doses but the pain isn't relieved, then one should be observant of the risk of uterus rupture or ablation placenta³¹.

Johanna started out by pointing out the benefits of an epidural; it helps the woman to handle the pain and to relax. But an epidural also involves risk in different ways. First, the epidural might lead to a drawn-out delivery that deviates from the expected pace. Second, increased amounts of analgesics were spoken of among the students as increasing the risk of conditions such as uterus rupture and ablation placenta. The pain women might feel then is different from the pain caused by contractions. The pain experienced when the uterus ruptures is a dangerous pain signifying that something needs to be done immediately. But, as Johanna explained it, there is also a risk of the midwife not recognizing that pain. She echoed here a discussion within the Swedish childbirth context, where labor pain and pain relief have been discussed in terms of risk. Too much pain, as well as excessive analgesics, are considered to pose a risk for the birthing mother and for the baby (Jansson 2008).

To summarize: The overall assumption that I detected in the midwifery education program was that a midwife's task is to help women handle labor pain. She should understand what they needed in order for them to feel that the pain was bearable. This meant that the students should learn how to handle different experiences of pain and decide upon the proper analgesics to be used. To find what Baker et al. call the "adequate analgesia" (2001: 172) is, however, not easy. As noted above, it is not always simple to estimate the level of pain that women experience. Factors to be included in the midwife's professional judgment were how different women might experience childbirth pain (as both sensory and emotional), what might affect their

³¹ Uterus rupture is a severe condition for both mother and child. The uterus ruptures, often in the scar from a previous caesarean section, and an emergency caesarean section is needed. There are different degrees of ablation placenta. It means that the placenta begins to separate from the wall of the uterus before the baby is born.

experience of pain (for example previous experiences, culture, social support), and the causes of pain (what happens in the body during the labor process). Based on this complex understanding, the students discussed what would be the most adequate pain relief methods, where breathing and relaxation techniques seemed to be the norm of how to handle normal labor pain.

Discussion

Midwives and midwifery students regard pain as more than a bodily sensation; it is something productive and meaningful in the birthing context. Midwives must learn to encounter pain as part of the normal process of giving birth and as something good that pushes the delivery forward.

However, they do not deny that being in labor and having contractions is painful for women, only that pain during labor is not seen as a reason to use analgesics. Labor should neither be free of pain nor too painfully experienced; there are situations where pain exceeds what is acceptable. However, the boundary between the good and normal pain and the bad pain is not that clear. This is apparent in several studies which have identified different attitudes towards pain, both among midwives and birthing women.

Diana Mulinari (2013) has identified two different stances towards pain among the midwives that she studied in a Swedish delivery ward. Some of them saw all labor pain as something that women could endure by approaching it in a positive way, whereas others focused on risk and categorized pain as either normal or pathological. My period in a delivery ward was too short for me to say whether this difference also applied there. However, I observed that women in this ward were asked more than once about how they felt about pain relief. I got the impression that they had been informed about different pain management choices in advance but were asked again if they had changed their minds (probably because they were now experiencing the pain).

It seems that the midwifery students that I observed were also taught to see pain as either normal or pathological; they learned as well how to help

women in pain to keep the pain manageable. Thus, there seemed to be one dominant way of approaching pain in the Swedish midwifery education that I observed.

The fact that approaches to pain differ between social contexts – and thus also the attitude towards different kinds of pain relief – has been shown by researchers including Bernike Pasveer and Madeleine Akrich for France and the Netherlands (1998). In the French setting (as in Sweden), births take place in hospitals, it is technology-intensive, and the midwife holds an important role in the birthing process through supporting the woman and guiding her through birth, including decisions on pain relief. Here – and in some contrast to Sweden – the normal birthing trajectory does not include intense or uncomfortable pain. Women are monitored intensively and the uterine contractions are artificially stimulated if these are not regular (i.e. productive). Pasveer and Akrich describe the French perception of pain in the following way:

Contractions are assumed to be physically (very) painful, and therefore dangerous, or distracting (from concentrating on the event of becoming a mother, etc.), or just too painful to handle in this particular setting. (Pasveer & Akrich 1998: 114)

Pasveer and Akrich contrast this perception of labor, which sees pain as dangerous and labor in need of constant monitoring, with the situation in the Netherlands. In the Dutch setting, home births are common and pharmacological pain relief is not available. Women's responsibility for their labor is seen as much larger than in France. "She is required to remain 'together': not to panic or to flee from contractions" (1998: 119). Thus women in the Netherlands are expected to be able to handle labor pain, neither panicking nor wanting to use analgesics. However, too much pain is understood as a complicating matter there as well.

Labor pain can also be seen as something that women want, have to endure, and thereby gain power. Cecilia Van Hollen's (2003) research in India has shown that pain and suffering are regarded as necessary ingredients in birthing for lower-class Indian women. These women claim that a baby will

only be born if there is intense pain. Labor pain is meaningful to them; to endure pain is closely connected to motherhood and through this suffering the woman will gain power. Therefore, many Indian women wish for induced labor and the use of Pitocin, a substance intensifying uterine contractions and pain. Hence, using analgesics to *reduce* pain would undermine these women's cultural identity.

Thus, there are different norms in different contexts about pain in childbirth and how to handle that pain. The midwifery students observed in this study spoke of pain as normal and productive. On the other hand, there is a thin line dividing normal pain from that which can be dangerous and threatening to the outcome of birth. The perception of pain as subjectively experienced means that the midwives must constantly estimate the pain women seem to experience, keep it at a manageable level and thus avoid a caesarean section which deviates from the norm about normal birth. The students must learn to handle both the good and the dangerous pain. They learn to estimate pain based on what the women in labor express, but also on what technology such as CTG presents, and how far the woman has come in the delivery process. As Akrich and Pasveer describe in their study, the contractions can be monitored through technology which "... makes the body talk more 'clearly'" (2004: 70). But a midwife must negotiate these different kinds of information and assess them in relation to each other. Sometimes contrasting images of pain appear, between what the woman expresses, the technology indicates, or the midwife's estimation of the number of centimeters the woman's cervix is dilated (i.e. how far she has come in the delivery process) and do not contribute to a coherent estimation of pain. The students have to learn how to be observant, for example, of contractions (as seen in the technology) combined with too little pain (as expressed by the woman), which may mean that the contractions are non-productive and the birth is not progressing according to the normal birthing trajectory. Thus, the line between the good and normal pain and the too weak or too bad and dangerous pain is fluid and negotiable. It becomes a matter of the midwife's professional judgment to prevent the birth from becoming complicated, for example, either by the woman becoming panicked because of immense pain

or a drawn-out delivery due to too little pain, both situations that could lead to a caesarean section.

8. The normal – and complicated – death

It was late April and I met with the third-semester students who had only six weeks until graduation. It had been a while since I last saw them and I was eager to join another collaborative group session and listen to their discussion. Perhaps my mood appeared a bit too bright because when we were seated, the teacher asked me if I knew about the day's topic. I had found the teacher's presence surprising, as teachers rarely attended group sessions during the third semester. But I understood why she was there when I looked at the schedule that said "perinatal death", and realized that the group session would be emotionally demanding. I felt my face stiffen and wondered how I could have forgotten.

The session was different from other collaborative group sessions in that the teacher took part in the discussion from the very beginning and actively led the discussion forward in a way I had only seen before with first-semester students. I assumed that the teachers had foreseen that one of them needed to be there due to previous experiences with other groups and the nature of the topic.

This session was unique not only because of the teacher being there and by its theme, but also in that everyone had read the same book from cover to cover. This was not the normal procedure at the midwifery education program, where the students usually individually chose literature from a reading list or searched for relevant articles. This time, and as a preparation for the session, the students had read *När barn föds döda* (When children are born dead) by midwife Ingela Rådestad (1998). The book is intended for students and personnel working with parents who have lost their children before birth. It contains guidelines on professional care: how to deliver stillborn babies, how to inform parents that their baby's heart has stopped working, and how to collect memories of the baby such as footprints and

photographs.³² The book includes quotes and experience-based stories told by parents and midwives, stories that show how a tragic situation can become even worse through the medical personnel's lack of caring.

The students' reading had been a noticeably emotional experience. They all looked low-spirited, and the first things said during the collaborative-group session were: "I read the book and I cried" (Louise), followed by "I didn't cry while I was reading but afterwards when I thought about the stories" (Sarah). The fact that reading the book had brought the students to tears immediately led the teacher to pose a question:

Teacher Is there something special found in the stories in this book that affects you, or is it just the fact that this [stillbirth] is part of life?

I perceived the teacher's question as rather provocative. After all, she straightforwardly said that sometimes babies die. She seemed to question how the students had responded to the stories about stillbirths – and thus implied that they, as future professional midwives, must learn to encounter such situations in a different way.

This chapter will discuss how the students and the teacher present at this particular group session spoke about how to handle the situation when a baby is born dead or its life is threatened, and the appropriate feeling norms when this occurs. The topic of the students' discussion this day was "perinatal death", but other complicated and potentially life-threatening situations were also evoked.³³ The session took up many different aspects: death as a

³² There is a whole section on how to photograph a dead child. It begins with quotes from parents showing how important photos are to them. Rådestad also describes how to prepare the baby for the photograph, and gives technical guidelines, for example about lighting and paper quality.

³³ Maternal mortality was not discussed during this session. Pregnancy- and birth-related mortality is rare in Sweden today. Esscher et al. (2012) show in a recent study that between 1988 and 2007, 491 women died for pregnancy- or birth-related reasons. Women who died during pregnancy or within a year after the delivery are included in that number.

situation, what death looks like in a baby, how death seems different in a midwifery context compared to a nurse's perspective, and how to professionally care for the parents.

I will show that the students had to learn to understand perinatal death as a “normal” situation in childbirth, and one that they should work towards making it resemble a normal birthing trajectory as much as possible. This was difficult for them; the session was emotionally intense, and the personal and the professional became intertwined in their discussion in a way that was not normally encouraged in the midwifery education.

Death as part of (a midwife's working) life

Childbirth is not always an event where a new life is born into the world. Sometimes babies are stillborn and show no signs of life at the time of birth. Stillbirth is when the death of a baby occurs before or during labor after at least 22 weeks of pregnancy.³⁴

Stillbirths may have reasons that a midwife cannot prevent events like infections, umbilical cord entanglement, prolapsed umbilical cord³⁵, or congenital defects. But sometimes there is no detectable cause (Siddiqui & Kean 2008). In Sweden, stillbirths occur in 3.7 out of 1000 births (*The National Swedish Board of Health and Welfare*, 2012). Compared to low-income countries, this is a relatively low number.³⁶ Even though these situations are rare in Sweden today, future midwives must be prepared to handle them, both practically and emotionally.

³⁴ The definition applied in Sweden changed in 2008 due to international practice, earlier on, intrauterine fetal death occurred by definition after 28 weeks of pregnancy (The National Swedish Board of Health and Welfare 2012: 48).

³⁵ Prolapsed umbilical cord is when the umbilical cord/navel string comes through the cervix while the baby is still in the uterus.

³⁶ For a discussion of stillbirth and neonatal death in Indonesia, a country with one of the highest number of child losses in Southeast Asia, see Andajani-Sutjahjo and Manderson (2004).

There is not much research on how midwives are affected by situations when babies are born dead or on how they learn to handle them. Laura Zeidenstein (1995) has encouraged a discussion among midwives about how midwives react when babies are born dead, which she claims affects them deeply. But midwives must also accept death as sometimes inevitable. She writes: "Like obstetricians, midwives must live with the knowledge that fetal/newborn deaths will happen again" (1995: 319).

That stillbirths are part of life and thus also of midwives' work is thus something that the students observed in my study also had to learn and accept. Still, they are emotionally demanding situations, as shown in how the students and teachers discussed it in the collaborative group session.

Understanding stillbirth: four themes

I found four different themes in the students' discussion when they tried to grasp how to understand death in the midwifery context and how it differed from how death was perceived in other caring professions, most notably in their previous roles as nurses.

The first theme found in the discussions concerns how the midwifery perspective of normality affects the students' understanding of death. Talking about and working with death is not something unknown to the midwifery students. They have studied the topic as student nurses and several of them have, as nurses, worked with patients with life-threatening diseases, as well as supported the patients' next of kin. Their strong reactions to a baby's death may therefore seem out of hand.

I want to explain their reaction by the kind of situation that they normally would expect as a midwife. When the midwifery students changed from being nurses to being future midwives they left the work of caring for unhealthy patients in need of medical care for a position of working with patients who are not sick but rather in a normal state of life. Death is not the expected outcome of a birthing trajectory; thus they have to learn a new approach to the situation as compared to what they did before. While death to a patient with, for example, an advanced cancer may seem by the nurses

involved to be a relief from pain and suffering (Blomberg & Sahlberg-Blom 2005), death within midwifery may appear as an unexplainable and tragic outcome.

The students' change of perspective on death from a nursing to a midwifery perspective seemed to me to have occurred during their second and third semesters, when they discussed complicated births. One example is given by Johanna. When I talked to her on my first day in the field, she was in her second semester as a midwifery student. She told me that she had previously worked in end-of-life care; she considered her experience of working with death to be an asset in her learning to become a midwife. Her saying this took me by surprise. I did not expect her to talk about the birthing situation as similar to one in end-of-life care. But because it was my first day among the students, I felt a bit tense and my mind was preoccupied by all the new people I had met, and I forgot to ask her what she meant by comparing working in end-of-life care and handling death in midwifery.

At a later stage, however, during the collaborative group session about stillbirths at the end of the third semester, Johanna seemed to perceive handling death in these two contexts in another way. She underlined the *difference* between experiencing patient death as a nurse and as a midwife. When she had worked with cancer patients, death was something beautiful and could be a relief, she now said. The patients and their next of kin had had time to prepare themselves for this situation. "But this, this really affects you", Johanna said, meaning the births of stillborn babies. She no longer compared this situation to encountering death as a nurse, where it was an expected or plausible outcome, but with the normal birthing trajectory leading to the birth of a healthy child.

Similar stories were also shared by the other students, which emphasized how the midwifery focus on normality affected the understanding of death.

Camilla I have met many people in my work who should not have died.
 They were healthy³⁷ and it is always tragic when someone dies

³⁷ I assume that she refers to those who have died due to different kind of accidents.

/.../ To have a baby is one of the greatest things that can happen in life. For most people, it is a happy moment. But if the baby is dead, it becomes such a sharp contrast. Suddenly it's the worst thing that can happen in life, I mean for a parent.

In the quote above, Camilla, just like Johanna, compared her work as a nurse with the work in midwifery. She, who had other work experiences, described death in general as tragic. But what makes death in the midwifery profession different is the perspective on normality. As a midwife, she expects the birthing moment to be a joyful event, and assumes that most parents feel the same way. The expectation of a normal birth is what she emphasized as affecting the perception of death in midwifery as different from death in other situations.

The second theme refers to how the students nevertheless had to accept that stillbirths do happen, and understand how a dead child may appear.

Camilla You've known about this, I mean, you know that this sometimes happens. There are many treasured moments in our profession and so much joy. But this, this is the downside.

Students spoke of death as an unexpected outcome of a pregnancy. They expect life, but sometimes, where the reassuring cry of a baby should fill the room, silence reigns. Even so, stillbirth is part of their work.

Johanna To prevent all stillbirths is not possible. There are some risk factors, like preeclampsia, that might cause the baby's death.

Cecilia But sometimes you can't prevent a death.

Louise No, you can't, as with some congenital defects.

Selma And sometimes you don't know why a baby dies while still in the uterus.

The teacher encouraged the students to discuss the topic in terms of the reasons for what might have caused the baby's death. She emphasized that it

was sometimes impossible for them to detect beforehand that the baby would be stillborn. In this excerpt, Johanna brought up a risk factor which they as midwives could be attentive to in the care of mother and child. The other students brought up situations when there is nothing they could do within their profession to prevent a baby from dying. In this way, the students worked to understand that stillbirths will continue to occur.

The students initially spent much time talking about why that happened, why a baby may die while still in the mother's womb, but also how a stillborn baby may look and feel when it is born. The teacher encouraged the students to talk about why the dead baby looks as it does. The students said that the baby's skin is most likely affected and fragile because the baby has been lying dead in the amniotic fluid, however, this depends on when death occurred. A stillborn baby is also warm at birth, even if it has died days ago, as it has been kept warm by being in the mother's uterus. In that respect, it feels just like a living baby.

The teacher also encouraged the students to talk about what the appearance of the dead baby may mean, to the parents and others. On the one hand, it may look different from a living child, and it is fragile, but on the other hand it also shares some similarities with a living child, such as it being warm. Because the baby is still warm when it is born, it is important to let the parents hold the baby as soon as possible, the students concluded.

The way the students discussed how the baby might look and how it feels to touch its dead body, implies that death in a midwifery context is somewhat special or at least different from other situations where they have encountered dying or deceased patients.

Johanna This [stillborn] baby is warm and soft, although it isn't crying. And it feels like-, I mean, it isn't cold as you would expect it to be, because it is dead.

Johanna compared the stillborn baby to how other deceased patients would appear and also compared it to the living child. A baby that has died before it is born appears in a way that fits in neither of these categories. It looks and

feels like a living child but there is an eloquent silence. There is both a similarity and a contrast to the situations that a midwife usually faces in her work.

The third theme that emerged in the student discussion concerned this contrast between the normal and the abnormal birthing situation, and how to support a woman giving birth to a stillborn baby. In Sweden, stillbirths are rare but even if it is known that the child is dead before labor starts, the birth takes place in the delivery ward among all other births. Thus, the delivery ward becomes a place where contrasting feelings meet:

Johanna They [the parents] are in a delivery ward, where there is so much life around them. There are pregnant women walking around in the corridors, happily looking forward to giving birth to their children. Meanwhile, you're there in a delivery room knowing that you're about to give birth to a dead baby. There's so much feeling right there.

Johanna here compares the experiences of parents of a stillborn child with those of other couples in the ward who she assumes happily anticipate the coming birth and to becoming a family. Their bereavement and loss may be even greater and something that midwives must take into consideration.

The students seemed low-spirited throughout the session and the teacher asked the students how they reflect upon being affected by the subject and how to support women giving birth to stillborn babies.

Louise I think that what one needs is to feel secure in handling normal births before handling these (stillbirths).

Sarah Yes, exactly. I feel that I want to know all routines and how to practically handle also these kinds of deliveries. I do not want to stand there and be uncertain of what to do. Perhaps you'll never be ready until you actually find yourself in such situation.

Johanna But perhaps one shouldn't wait too long. Otherwise one might be scared of it.

In the excerpt, Louise and Sarah emphasized that knowing how to handle normal birth, and feeling confident with it, is needed before they can feel that they could handle stillbirths. Thus, they indicated that work experience is also needed to be able to handle all kinds of situations that a midwife might face. But it should not be something they fear, as Johanna said.

In other countries, such as Britain, births can be spatially separated according to how they are categorized, as normal and complicated (Rayment 2011). Consequently, midwives in a “normal” ward in Britain have little or no experience of deliveries with stillborn babies. In the other ward, midwives daily helped women give birth to stillborn babies or with other kinds of pregnancy loss, and also handled complicated pregnancies. Juliet Liand Rayment describes in her study that how the midwives perceived stillbirths was affected by this separation in space; death was either absent or overrepresented. The fact that all births take place in the same ward in Sweden, I claim, has an impact not only on the patients’ experience, but also on how the midwifery students discussed perinatal death in relation to the normal birthing trajectory; this leads up to the fourth theme.

The fourth theme that emerged concerned midwives’ responsibility to make the labor progress according to the normal birthing trajectory, in a situation of stillbirth as well as that of a normal birth. As shown in previous chapters, a normal birth is a vaginal birth, where the woman can handle the birthing pain and will gain a positive birthing experience. The health of mother and child is good and the couple becomes a family at the moment of birth. When, on the other hand, the death of the child has been detected before labor begins, the aim is still to strive towards a normal birthing trajectory. This means, among other things, that the birth should take place in a delivery ward. And even if the child has been detected as dead before the labor starts, the birth should follow the normal birthing trajectory. This means that vaginal birth is seen as preferable, even if the woman may wish for a caesarean section, because the risk for the woman’s health with a vaginal birth is then considered to be lower than with a surgical intervention.

The aim towards a “normal” birthing trajectory also means that the woman and her partner should become parents. One of the students said the following about supporting parents who give birth to a stillborn baby.

Louise It is still a baby. It is their baby.

During the collaborative group session about stillbirth, the midwifery students and the teacher kept on referring to the woman and her partner as “the parents”, just as the book did. They become parents and, at the same time, parents who have lost their child. “The first encounter also becomes a farewell,” as one of the students said. Thus, the fact that the baby had died should not deprive the woman and her partner of becoming parents or from having a vaginal birth in a delivery ward with only the assistance of a midwife (that is, with a doctor only involved if the midwife estimates the birth as complicated).

As shown, the students spoke of handling stillbirths as working towards as normal a birth as possible. They did this through emphasizing the normal aspects, not only of the birthing trajectory but also of the whole pregnancy. In the following excerpt, the students discussed stories told by parents in Rådestad’s book.

Sarah When she [the mother] described her boy, whom they called Erik, she tried to focus on the nine months when he had been alive and kicking. She was happy for that time. /.../ I think that it is something one should think about when meeting those women who have carried their babies full term. I mean, one could work on emphasizing that time and try to help the women to think of it [the time when the baby was alive] in a good way.

Louise One of the fathers in the book [by Rådestad] wrote ‘We prepared and planned when to go on parental leave. We bought a baby carriage. All those practical things were such fun’. He wrote that he had warm memories of those times.

However, the students declared that such stories could not be told to parents in the delivery ward who are about to give birth to a stillborn baby, as they had been said by other parents years after their losses. Nevertheless, the students brought them out as examples of how one could try to see the normal in abnormal situations. In that way, they acknowledged the parents' experiences as part of a normal trajectory.

Professional feeling norms about how to handle stillbirths

When a woman gives birth to a stillborn baby, death appears in sharp contrast to most birthing situations and to what usually happens in the delivery ward. How midwives should handle stillborn babies and support parents emotionally is a complex and demanding task. Rayment describes in her thesis about midwives working in British delivery care that the midwives found it stressful to support the parents and care for the dead baby (2011: 152: ff). Others have shown that it may also be rewarding to be able to help the parents in their grief (McCool et al. 2012, Bolton 2000). Rayment, who is inspired by Hochschild's theoretical perspective on emotions, describes how the midwives in her study worked on their emotions and tried not to cry in front of the patients because that would make it difficult to support them (2011: 153).

These contrasting feelings and how they should be expressed in a professional way were also present in the students' discussion. Midwifery students and teachers often spoke of "a midwife's professional attitude":

- Camilla You have to try to put your own feelings aside. [Camilla moved her right hand to her heart, closed it, and determinately placed it at the table.] At least until you're out of the [delivery] room. We do have feelings. Of course we're affected by it!
- Johanna Yes, we're not robots

Midwives do not see themselves as cold-hearted robots; they are affected by difficult situations. But, as Camilla implied, there are norms about when and

where you may show your feelings. In a difficult situation you should express yourself differently inside the delivery room and outside of it, where there are no patients present. In the delivery room you should normally not be overwhelmed by emotions, neither joyous ones nor sorrowful ones. Whereas (as discussed in Chapter 5 above) the students sometimes found a few tears of happiness to be allowed in the delivery room, they all agreed that breaking down in tears was out of the question, no matter what the reason. This feeling norm was also confirmed in the collaborative group session about stillbirth.

The midwife plays a supporting role in relation to the parents during the labor process. In situations when the baby has died, the midwife should still be supportive, but in a different way compared to what happens in normal births. Thus the students discussed the proper ways of offering support to parents who have lost their child, based on the book by Rådestad. She offers some advice on how to act with parents during labor: one should look the parents straight in the eyes and not avoid them, nor should one ask the parents if they want to see the baby, because the question implies that this is not obvious and may make them feel insecure. When the baby is born, the midwife should treat the stillborn child as any other child and hold it as if it were alive. The book also gives advice about how to comfort the parents “in the right way” and lists what to say and what not to say to them. For example, one should not say to a young couple that they, because of their youth, have chances of having other babies in the future. Nor should a midwife try to comfort parents whose baby had a congenital defect by saying that it was better that it died now rather than later (Rådestad 1998: 86-87).

Several examples in Rådestad’s book concern situations narrated by parents, when midwives or doctors acted in a coldhearted and inattentive way. They serve as examples of what not to do. The students reacted strongly to these stories about parents being ill-treated or not properly cared for after the loss of their child. They were upset and angry, questioning the midwives’ and doctors’ behavior, which seemed not to correspond to what they felt were norms about how to encounter grieving parents. They also had examples of their own of feeling norms not being upheld in situations of

complicated births, where they repeatedly stressed the importance of never ever being anything but strong and supportive to the parents.

Student Selma gave an example of what a midwife should not do when the baby's life is threatened during labor. It happened in the second semester during her practical training in a delivery ward. I had heard this story once before, in a collaborative group session soon after it had happened. At that time, the story came up when the students discussed complicated deliveries. This time it was part of the discussion about the importance of behaving professionally when women give birth to stillborn babies.

Selma There was this thing happening when I was at the delivery ward, the shoulder dystocia, you know. The baby was delivered stillborn and the doctors rushed it out of the [delivery] room³⁸. I stayed in the delivery room by the mother's side while my supervisor crouched down on her knees and cried loudly! It is so important that you act in a professional way. I felt like...Well, I just stood there, by the mother's side. The situation obviously affected me too, but a supervising midwife – to cry like that!

In Selma's story, the baby's health was assumed to be good up until the shoulder dystocia, which is a severe situation that can occur during the final stage of a delivery. The baby's head is delivered, but then its shoulder, or shoulders, is caught, preventing the rest of the body from following. The shoulder dystocia causes asphyxia, i.e. a lack of oxygen and may lead to permanent damages. The baby in Selma's story was so affected by the lack of oxygen that it showed no signs of life. When she told the story the first time, directly after it had happened she included the baby's status and the woman's reactions.

³⁸ If a baby does not start to breathe after it is born, doctors treat it in a specific room in the delivery ward where there is adequate equipment.

- Selma First, they [the doctors] used a vacuum extractor because the contractions were weak and she [the birthing woman] had no strength left. She had struggled for so long. /.../ And then, the baby's shoulders got stuck.
- Camilla What happened to the baby?
- Selma It did not do well. It convulsed all night. She did not do well at all. It was very sad.
- Teacher How was the mother doing?
- Selma She was in shock. She didn't understand what had happened or why. It was her first child. One had to try to talk with them [the parents]. First, she repeatedly said 'as long as the baby is doing all right'. I couldn't keep my feelings away, but I couldn't show that. My supervisor was down on her knees because she was so affected by the situation.

It was not the same teacher present at this session as in the session about perinatal death. In the session where the story first appeared, the teacher steered the conversation towards how to handle such complicated situations and the importance of everyone knowing exactly what to do. The delivery in question thus became complicated and required both doctors and an additional midwife to be present in the delivery room. The situation was very tense, but according to Selma, the supervising midwife did not act as she should. Her behavior was unprofessional in several ways. Not only was the situation with the complicated delivery tragic in itself, but what made it even worse was that the midwife failed to maintain a professional attitude, both towards the patient and in her supervision of a midwifery student. Also, the other students' response to her story was very strong.

- Johanna One can of course become teary-eyed and affected by the situation. But one cannot break down and not be able to take care of the woman. /.../ One has to be strong and support the parents.

Johanna confirmed the feeling norm of what a professional midwife cannot do in a critical situation and why – she needs to be able to support the parents, which she cannot do if her own feelings are too intense. Louise further described the proper way of supporting a patient when a situation such as a shoulder dystocia has happened.

Louise In emergency situations, well in all difficult situations, I think that one has to be brave enough to care for the persons [the parents]. What I mean is to look them in the eyes and straightforwardly explain what is happening.

Several feeling norms seem to be present in Selma's story and to be confirmed by Johanna and Louise; they concern the relationship with the patient, between a supervising midwife and her students, and between colleagues. In general, a midwife or a student midwife should not break down in tears in the delivery room. You cannot support the mother and cry at the same time. A midwife supervising a student should, in addition to being supportive to the patient or parents, also support the student, who may be in shock from attending a situation never previously encountered. The feeling norms applicable to a midwifery student in such a situation seemed to be that she should try to control her emotions, to help the supervisor to support the patient – but not, as in Selma's story, have the main responsibility for support. Hence, the students' strong reaction towards the supervisor's behavior indicated that she had failed both in being a professional midwife and a professional supervisor.

Selma also said that she cried afterwards, but not in front of the parents. The other students instantly confirmed that her behavior was correct and that she of course should be allowed to express her feelings to her colleagues, although not in the delivery room. Thus they confirmed that she had acted in a correct way; her behavior corresponded to the feeling norms about where and to whom to express one's emotions, and where not to do so.

Right after Selma's story, another student, Sarah, shared a story from her practical training in a delivery ward during the third semester. This was also

about a situation when the lives of both mother and baby were threatened, but where the situation was handled professionally by the midwife involved.

What happened was a uterine rupture, a rare but serious complication. Students had learned to identify uterine ruptures and they knew what to do when they occur. Sarah described it as a horrifying experience, but one that her supervising midwife handled in a professional manner. She had quickly identified the situation through her assessment of the patient's clinical symptoms and her interpretation of the graphs, and she immediately called for help. The baby was delivered with an emergency caesarean section, and resuscitated; it was, according to information the following day, "doing all right under the circumstances". All personnel involved gathered afterwards, talked through what had happened, and cried together. In Sarah's story, another feeling norm appears, namely that colleagues are expected to share their feelings with one another and cry together – or at least accept that others cry – after a complicated situation such as the one that Sarah talked about.

The teacher asked Sarah to clarify in which ways she found the situation to be handled professionally, besides that there being a calm atmosphere. Sarah first responded by mentioning the practical procedures and thereafter how the midwife upheld a professional attitude throughout the situation.

Sarah The father wasn't properly taken care of, but he was provided for later. It was..., how can I say this... . She [the midwife] was direct in her information, everyone kept calm, and there were only straight instructions and no fuss. She even included me and told me what to do. I mean, it was all serious and yes, I would say very professional. She was calm and delegated the others with a matter-of-fact manner. I felt that she never lost control.

Selma Well, there you see the difference, that she was calm. Mine [the supervising midwife] cried out: 'I can't do it! This isn't working! Oh, come on!'

For Selma, the main difference between the two midwives' behavior was that the one Sarah worked with stayed calm and took control of the situation, whereas her supervisor became so scared that she could handle neither her feelings nor her actions towards the patient. In addition, Sarah's supervising midwife included her student as part of the team and told her what to do. Selma, on the other hand, was on her own without her supervisor's support and did not know what to do. Her fellow students and teacher confirmed that she had done the right thing in staying by the mother's side, but she had also needed to hear that from her supervising midwife in the delivery room.

What also appears in the students' discussion is expectations of how a midwife should handle different kind of situations and her responsibilities in work. The students' examples and discussion thus indicate what seem to be important professional norms about how to act and feel in situations of stillbirths or when the lives of mother and child are threatened. A midwife needs to be in constant control of her feelings, be supportive, calm, firm, and secure in her work role. She should be ready to recognize and handle any possible situation that may appear in the delivery room. Once outside the delivery room, she may, and sometimes also ought to, show that she has been affected by a difficult situation. She should share her feelings of grief with her colleagues (and only her colleagues) and they should be able to offer support to each other, as well.

Feelings of responsibility were also included in the discussion about why Selma's supervisor acted the way she did and thus was not able to properly support the woman.

Johanna Could it be so, that she [Selma's supervisor] blamed herself, that she felt that she hadn't been a good midwife or carried out her job in a good way?

Johanna pointed out that the question of responsibility might also be a reason for the supervisor's intense feelings in the delivery room. McCool et al. (2012) point this out as a reason for why birthing situations with tragic outcomes are difficult for midwives to handle: there is a fear of being

responsible, of not having done everything that a midwife ought to do in this situation, and also the risk of being reported to the authorities. As Becker et al. also show in their study of medical education, the question of who is responsible is always present in medical practice, as the patient may die even if all the right decisions have been made ([1961] 2004: 225).

In Sweden, caregivers are obliged to report to *The National Board of Health and Welfare* if they suspect that there has been a negligence of the rules; they file what is called a “Lex Maria complaint”.³⁹ When I conducted field work at the midwifery program, I did not hear anyone speak of “Lex Maria”, that is, of what a student should do if she observes a situation that was not handled according to the rules, or what the students should do if they themselves failed to carry out their work properly. However, even if I did not hear that kind of discussion, this does not imply that “Lex Maria cases” were never brought up; they could have been discussed when the students trained to become nurses.

When personal experiences and professional norms meet

Throughout my field work at the midwifery education program, I expected to find situations where it became impossible for the teachers and students to distinguish between their personal and professional lives. Students sometimes, during lectures and collaborative group sessions, brought up personal stories of pregnancy check-ups and childbirth, but these were not discussed in any detailed way. In general, both students and teachers seemed to perceive that the professional and the personal could be separated, and that their personal feelings, other than those included in the professional attitude, should be subdued.

Indeed, the teachers actively worked towards keeping the students’ personal experiences out of their discussions about midwifery and deliveries. They also tried to gender-neutralize the profession, by underlining that

³⁹ Health-care givers or health-care practitioners can hand in a “Lex Maria complaint”. The health-care givers are obliged thereafter to start an investigation.

women did not have special knowledge required in the profession, just because they were women. One way to do this was not to talk about the students' personal childbearing experiences. The collaborative group session about stillbirths, however, was an exception. There the students' personal experiences were acknowledged and discussed. The teacher actually encouraged a discussion where the students could reflect on how the personal and the professional might overlap.

In a study of medical students, Becker et al. show that to the students all deaths seemed alike. It did not matter whether the deceased was an old person or an infant. However, there was one exception to this rule; the students became affected when someone of their own age had an accident. Then they felt that it could have been them ([1961] 2004). In a similar way, the midwifery students became emotional in the session about stillbirth in a way that I had not seen before. "It could have been me", as one of them said during the very first minutes of the collaborative group session. The conversation kept coming back to the fact that losing a child could happen to any one of them, or may already have happened. Three of the six students in this group were parents and all students were in relationships. This was the first time I found that their personal experiences of pregnancy and miscarriage affected them to such a high degree that it became impossible not to bring them up, and tears were shed more than once.

The students described death within midwifery and the loss of a baby as tragic and unexpected. It could happen without warning to anyone; they could themselves be that patient who loses her child. This was echoed by the teacher, who offered the students an explanation to why the topic of stillbirth had affected them to such a high degree:

Teacher You are all young, fertile women. Some have small children and you might think, 'What if this had happened to me?' and if you want to have more children... This is... Well, this is how it is to be a midwife. And it's really hard at your age."

The students' experiences as midwifery students had also made them reflect upon their previous work as nurses. One student said that she was appalled by the self-care advice she had given women who had had early miscarriages and who had called for advice at the gynecology ward where she previously worked. She had told them that there was nothing to do and that the body would bleed everything out.

Cecilia Now, as a midwife I would say [to a woman who's calling in suspecting an early miscarriage] 'come in for an examination'. This is partly because of where I am in life right now, but also because of everything that we've read. ... I've completely changed my approach to this.

Even though there may not be any medical reasons to examine the patient, a midwife should offer support to a women with a pregnancy loss. This was in line with the professional norms of support that the students were taught and often discussed. But Cecilia's personal life experiences also affected how she viewed her work as a midwife. She said that she wanted children of her own, and could now imagine how she would have reacted if she had been given the advice that she had given the women who called in when she was a nurse – it would have been terrible.

Cecilia was not the only one who spoke about how being a midwifery student and having difficult personal experiences intersect with and influence how she saw issues of miscarriage and stillbirth.

Emma I also feel that... I haven't told anyone but I had a miscarriage during this last practice in a delivery ward, so that's probably why I feel... I'm sorry. This affects me a lot. [Tears ran down Emma's cheeks. Everyone quietly waited for her to gather herself together and continue.] That's why this is very hard for me. I feel fine now and I agree with you [Cecilia], that early miscarriages are put into a completely different light.

Emma continued that, with everything she had been through, she would not be able to handle a birth if it was known that the baby had died; she would not be able offer proper care to the woman. “But I hope that one day, whatever life has to offer, I will be able to work in all areas of midwifery,” she concluded. While Emma’s experience of a miscarriage made her feel that she could not face all the situations a midwife does and hence prevented her from adequately supporting women with pregnancy loss in her coming profession, Cecilia presented her experiences as rather helping her in her job. A similar reaction was shown by midwives in the study by Rayment; they let their own experiences of pregnancies, births, and miscarriage affect how they encountered women in similar situations in a more supportive way (2011: 146).

Discussion

In these two final empirical chapters about pain and death, I have shown how the students discussed ways to understand and handle pain and death as part of their work. Pain is good and normal and it brings the delivery process forward, as long as it is a good and normal pain (which means that women should not be so affected by pain that the midwife cannot communicate with her). This norm meant that midwifery students’ feelings towards pain had to change. They had to learn not to feel sorry for the women but rather cope with working with women in pain and support them in appropriate ways.

As the discussion about stillbirth shows, the students also had to change their perception of death and learn how to handle it within the midwifery profession. Sometimes babies die and there is often very little they as midwives can do about it. To perceive death in this way, they would also have to change their feelings towards it. They would still be affected, but they should accept death as something that could and would happen, sometimes in unexpected ways. They learned ways to make the stillbirth follow a normal birthing trajectory, to handle the stillborn baby in a respectful way, and to support the parents without being too affected themselves. However, it

seemed much harder for the students to accept death in a child than to accept pain in the birthing woman.

Learning how to cope with difficult emotional situations was part of the students' learning process. During the first semester they were taught that most pregnancies and childbirths are normal. During the second semester they then were taught about complicated pregnancies and childbirths and learned how to manage them to protect the health of mother and child. Finally, during the third semester the students had to understand that there sometimes is nothing they can do to prevent the death of a child. Hence, they went from seeing most pregnancies and deliveries as normal to having to accept that, even if everything seems normal, the baby might die.

In a study of how nurses learned to handle emotionally intense situations when caring for dying patients in an emergency department, Cara Bailey et al. (2011) show how the nurses through reflecting upon their personal experiences, what Bailey et al. call "self awareness", learned to better care for the dying and also develop in their professional role. The midwifery students' discussions presented in this chapter, which included both personal and professional experiences, can be seen in a similar way. They were meant to develop a professional self-awareness and the proper feeling norms in situations of great emotional distress. Because the students' experience of handling stillbirths was rare, experienced-based stories told or read about served the purpose of sharing knowledge of the kind of situations that may happen and how to care for the parents emotionally. The stories facilitated the recognition of certain complicated situations and the appropriate feeling norms. In this way, the midwifery students and their teacher worked together to change the meaning of situations of death and thus affect their feelings towards it.

Some studies of midwives' emotional labor in delivery wards (Rayment 2011) or of nurses within end-of-life care (Blomberg & Sahlberg-Blom 2005) show that these medical professionals try to harden themselves and keep an emotional distance to their patients, in order to carry out their work. They learn to "mask' their feelings", meaning to hide their feelings or reactions and express what is expected of them in the work role. Thus Bolton explains that

the gynecology nurses in her study try not to become too personally affected by the tragic situations they face (Bolton 2000: 584). I would argue that the midwifery students' discussions of stillbirth and other adverse situations show a more complex picture. In the midwifery education program, no one spoke in terms of "feeling norms" but rather about "a midwife's professional attitude." In normal births, keeping a professional attitude includes being supportive and not acting overly happy when babies are born. In difficult situations, the norms seemed to translate into staying calm, being supportive, and appearing to be in control of the situation. One should not be scared or surprised by how a stillborn baby might look or feel, or break down and cry in front of the parents. But this does not mean that they "harden" themselves or "mask" their feelings. Instead, the feeling norms put forward were to be supportive and not be too sad when babies are born dead. The students were expected to learn this through understanding why stillbirths sometimes happen, accepting that they may happen, and emphasizing all the normal aspects of those pregnancies and births as well.

9. Conclusions: Negotiating the normal birth

Midwives' work in delivery wards is autonomous work that builds upon collective understandings and norms about how to carry out the work. For midwives, delivery care is often characterized by short and intense encounters with birthing women. This means that a midwife needs to quickly get a picture of the status of the delivery and of what kind of support the woman needs, in order to ensure a normal birth. Sometimes the birth becomes complicated and, in rare cases, the baby is stillborn or dies at birth. Future midwives thus have to learn not only the medical and technical aspects of their profession but also how to encounter patients' feelings in different kinds of situations and how to display the professional feelings appropriate for a midwife. I have investigated how such concepts are presented to and understood by students in midwifery education. Inspired by a situated learning perspective as well as by sociological and anthropological perspectives on emotions, my study shows how students in a midwifery education program discussed norms about birth and feelings as part of learning the profession, how they contrasted them with earlier norms, and how they questioned and negotiated what the proper professional attitude should be.

Previous research on cultural perceptions of risk in pregnancy and childbirth, and on pain and technology in childbirth, has shown that feelings in childbirth, pain, and the use of medical technology are not uncontested. What is considered normal practice is culturally and socially constituted, and is thus changeable. This study adds to these discussions by analyzing how such norms of proper practice are learned in the process of becoming a midwife, that is, in midwifery education. I would argue that the educational context makes implicit norms explicit; in the process of introducing newcomers to the

profession, the proper professional attitudes are elucidated, discussed, and sometimes contested.

In contrast to previous studies of midwifery education that have concentrated on practical training in wards where students learn from experienced midwives, my study focuses on classroom training. It is based on a field study in a midwifery education program in Sweden, where I observed students during parts of their university-based training. It explores how they talked in group discussions and informal conversations about how to handle birthing situations and negotiate the “right” feelings in their work. The students learned from one another as much as from teachers and from supervising midwives during practical training. The delivery ward was indirectly present in their discussions, as a future professional destination and as a site of experience-based stories about the practical training that the students underwent during parts of their education. To gain some insight into everyday work in delivery care, I also did a few days of observation in a delivery ward.

I see the midwifery students’ sharing of experience-based stories and discussions of cases as a way for them to build what Mäkitalo (2012) calls a *body of knowledge*. In this case it concerns how to recognize the normal and the complicated birth, how to categorize births and patients, and how to correctly handle different kinds of birthing trajectories. My specific focus is on the professional norms involved in this work. The students are expected to recognize and adhere to prevailing norms, to what they and their teachers discussed as the proper “professional attitude” towards pregnancy and delivery. To be a “good” practitioner thus includes adhering to norms of how to do the right thing for patients, both medically and emotionally.

As discussed in the theoretical chapter of this thesis, norms define both the ideal and the standard way of doing something within a community of practitioners; they include both the desired and the acceptable behavior. I have shown that the line between these two, as well as what they imply, was not self-evident; instead it was something that the students questioned and negotiated. In this final chapter I will analyze these negotiations under two

headings: *Norms about the normal birth* and *Feeling norms in midwifery*. What they refer to is intertwined, but is kept apart here for analytical purposes.

Norms about the normal birth

Norms about the normal birth are complex and ambiguous. Still, it is a central professional category within midwifery, as taught in the midwifery education. Midwives start out by assuming normality in pregnancy and birth, something which also affects how the midwives' role is perceived.

In Chapter 4, I introduced the concept *normal birthing trajectory*, inspired by Strauss et al. and their analysis of illness trajectories (1985). This concept made it possible to understand how normal birth is situated in a technology-intensive hospital environment, how the medical personnel defines a normal physiological and psychological progress of birth, as well as what the midwife, the birthing woman, and her partner should do and which feelings they are expected to experience and express.

The normal birth was defined through several intertwined aspects. It should start spontaneously after a full-term pregnancy. When the woman and her partner arrive at the delivery ward, the midwife conducts different examinations to establish the status of the birth and then supports the woman throughout the delivery. The progress is then expected to follow at a certain pace. The woman should experience the birth pain as bearable and be supported by her partner throughout the labor process. The labor ends with a vaginal birth and the woman and the baby should be in good health. At the moment of birth, the woman and her partner become parents, and the three become a family. Hence, the partner holds a prominent position in the normal birth, both as an active supportive person as well as in the role of a parent. Everyone involved sees the birthing experience as positive, which indicates that the women could imagine herself going through vaginal birth again in future pregnancies (and thus not be so scared or in such pain that she would want a caesarean section).

The norm about the normal birthing trajectory implies that if a deviation is detected, midwives strive towards keeping the birth as normal as possible.

For example, if a labor does not start spontaneously, labor is induced in order for it to resemble a normal labor process. If the woman expresses intensive fear of labor, the midwife tries to calm her down so that she will have a positive birthing experience. And if the pain is too intense or not productive, and does not bring the birth forward at the expected pace, the midwife and doctors will offer the woman different kinds of pain relief methods or artificially stimulate the uterine contractions.

Sometimes deviations are not easy to detect, or are subject to interpretation. The normal birthing trajectory may be threatened by how the woman reacts towards giving birth. In Chapter 6, I developed the concept *predictive marker*, inspired by Mesman's (2005) concept prognostic marker, to show how students discussed how to recognize if a patient's attitude deviates from what she is expected to feel in a normal birthing trajectory, and whether it may threaten the normal birth. The students were introduced to predictive markers concerning women's social background and previous experiences; these markers characterize psychosocial risk factors which may make for a possibly problematic delivery. However, many of these markers seemed vague to the students, and were contested by them. Also, in some concrete situations of panic among birthing women related by the students, no well-known predictive markers seemed to apply.

Patients who were pre-categorized as being extremely scared of the delivery, so-called Aurora patients, seemed to be easier to understand and handle. Here the norm also seemed to be that the delivery, despite their fear, should follow the normal birthing trajectory. Thus, the challenge was how to prevent a normal labor from becoming complicated. The students had to find ways and arguments to handle the patients' emotions so that the labor could end with a normal delivery, that is, a vaginal birth where the normal bodily and emotional trajectories run parallel.

The overarching norm concerning the normal birthing trajectory was that it was the *woman* who gave birth – the midwife was there mainly to *support* the woman's own efforts and to ensure that everything went well. Thus, much of the students' discussions concerned how they as midwives could support the patient towards normal birth and a positive birthing

experience (or at least prevent such terrifying experiences that she would fear another delivery in the future and thus prefer a planned caesarean section). This support became challenging in situations of pain. Support for women in pain was based on the notion of pain as good and productive and something that the women could endure, a notion that differed from what the students had experienced previously, as nurses. Then, all pain was seen as negative and should be prevented. Thus they had to reconsider their attitudes towards pain and also towards what kind of support they should give to a patient.

Previous research, such as that by Mulinari (2013), has shown that midwives in delivery wards may have opposing positions about pain and about what women are able to handle. Some saw birthing pain as something that women can and should tolerate (in a sense that pain is something good), while others perceived pain as something that could be categorized as either normal or pathological and adjusted their support accordingly. The midwifery students in my study only discussed the latter of these perspectives. The collective perception of pain present in the education seemed to be that it should be bearable to the woman and that too intense pain could threaten the normal birth. The appropriate way for the midwives to support the woman should be based on their professional judgment of the level of pain and of the adequate pain relief methods. This in turn was to be based on midwives' knowledge about appropriate pain relief during different stages of birth, on their estimations of how far the birth had proceeded, on the signals from the technology used – as well as on the woman's experience of pain and the kind of pain relief that she may want. Thus in this discussion, the norm was also that of the woman given an active part in the birthing trajectory, both in terms of her bodily and emotional changes throughout the labor process and also in how she expresses her wishes about, in this case, pain relief.

Issues of support and the midwives' role became particularly salient when the students discussed the proper feelings within midwifery, something to which I will now turn.

Feeling norms in midwifery

The midwifery students talked about the proper “professional attitude” in different situations. This attitude includes which kind of emotions a midwife ought to feel and express, those which I call feeling norms. These feeling norms were not merely about acknowledging the right or wrong feelings; they elucidated how meaning and feeling were intertwined. The midwifery students contrasted norms in midwifery with those of other occupational groups, for example the nurses or doctors that constitute other occupational groups also working in delivery care.

My study links to what Sigridur Halldorsdottir and Sigfridur Inga Karlsdottir (2011) have analyzed as “core values” within midwifery, that is, norms about how to be a professional midwife. The core values include how midwives should care for the whole family in the birthing situation and how they should empower birthing women. The good, professional midwife is someone who simultaneously keeps a professional distance and shows a personal engagement. What my study adds to this is a more complex understanding of professional feelings in different situations and the fact that a professional approach is something that needs to be learned and reflected upon.

I have used a perspective on emotions as both subjectively and collectively experienced, and as part of the professional role within a (loosely defined) community of practice. To understand such collective norms about feeling, I have turned to the work of sociologist Arlie Russell Hochschild (1979, [1983] 2012). Hochschild uses the term *feeling rules* to understand “the *extent*”, “the *direction*”, and “the *duration*” of how a person ought to experience feelings and express emotions in specific situations. These “social guidelines” tell the person which feelings are appropriate in a situation and remind him or her how to feel, how to express emotions, and to what extent emotions are allowed (Hochschild 1979: 563f, italics in the original).

Hochschild and others who have applied her framework (e.g. Bolton 2000, James 1992, Savage 2004), highlight that the handling of emotions largely applies to female-dominated occupations. They elucidate expectations

within organizations about what kind of emotions individuals are expected to express as part of their work role, as well as what kind of feelings they are expected to evoke in their customers/clients/patients.

While being inspired by Hochschild's approach, I have used the concept *feeling norms* instead of feeling rules, as this term, in my view, is less imperative and also links more clearly to a social community. As seen in the students' discussions, there is an open-endedness around what feelings are appropriate; there are different and even contradictory interpretations of what a feeling norm may be, as well as of when and how it should be applied. In addition, the concept opens up to include both "the usual way" and "the ideal way" of how feelings are experienced and expressed. These ambiguities were present in several of the students' discussions, for example when they described how their supervisors during practical training in delivery wards had acted in different situations. Good and bad examples were brought forward as ways to problematize what might be the proper midwifery attitude, especially in difficult or suddenly changing situations. Thus, how *not* to behave was, in many discussions, as important for an understanding of the appropriate feeling norms, as were more positive examples.

In accordance with Hochschild, I have underlined that feeling norms are not only about suppressing one's emotions and keeping an emotional distance to the patients, something that has been emphasized in previous studies of care work. It is also about making others feel safe, happy, and content. A midwife normally assists at a happy occasion, which is characterized by delight and joy. This puts a demand on midwives to act in not only a controlled but a positive way. Thus, in Chapter 5 I show that midwifery students were allowed, and even expected, to cry for joy at their first experience of a birth. Thereafter, the feeling norm was that one controlled one's emotions and got on with one's work. Midwives should not be too taken by the situation but "moderately happy" and thus not let their feelings overwhelm the parents. The mother was after all the one who, according to the norm of the normal birthing trajectory, had done the job. This also meant that a midwife should not show open pride in her work, or expect excessive gratitude from the patient for something that was part of her job of support. It is the woman who

delivers the baby, not the midwife. Rayment (2011) shows similar results in her study among midwives in the UK. If a woman feels that she accomplished the birth by herself, the midwife has succeeded in her work.

In the work by researchers including Hochschild and Rayment, the feeling rules are not questioned. It is also taken for granted that workers know what the feeling rules are. In Rayment's study of experienced midwives, she argues that midwives have learned about the feeling rules during practical training (2011: 139ff). Blåka's study (2006) about midwifery students learning also argues that students learn from midwives in the ward. Thus, these studies take the rules and norms more or less for granted. In contrast, my study focuses on the process where midwives-to-be try to identify what the feeling norms are (and are not), and reflect upon norms about a professional approach or the different ways in which midwives may approach situations. I also show that they sometimes questioned the norms presented in their school-based education as well as in their practical training in the wards. The students both questioned how some midwives in the ward had handled some situations and idealized the approach of others. In addition, it was not always apparent to the students what the norms were or what they signified. However, they strived towards finding the "proper" feelings in different kind of situations and patients, and what kind of behavior that implied. The feeling norms were not simply about, for example, whether a midwife could weep or not. It was about learning why and in what situations she could or could not weep, and how. In a way, these negotiations resemble how the flight attendants studied by Hochschild try to find strategies of how to express the "right" emotions in accordance with the feeling rules.

Throughout the study I have argued that midwives' professional feeling norms about how to encounter birthing women are intertwined with how they understand a normal birth, i.e. what Leavitt (1996) describes as meaning and feeling being intertwined. The normative assumptions of birth are that it is so beautiful that it will bring a midwife to tears if she does not control her feelings, and also that midwives attend birth to offer support and should for that reason not show pride when the birth goes well. In Chapter 8 I show that

tears are not allowed either in the opposite or contrasting situation – when a birth becomes complicated, even tragic, and death occurs.

In the thesis I have concentrated on two contrasting situations: a normal birthing trajectory and one ending in tragedy, a stillbirth – what feelings to express then and how to do so. This latter situation challenged the students' conceptions of birth, as well as their conceptions of death as experienced in their previous work as nurses. Death from a nurse's point of view could then be seen as relief from pain and suffering; in the delivery ward, however, they saw it as an abnormality, as a deviation from the normal birth, and an offense. What they had to learn, however, was to see stillbirth as something normal within delivery care, in order to handle it in a professional way with the appropriate feelings and attitudes. It was normal, in the sense that it did occur now and then, but it was of course not a desired outcome of birth. It was, as one student said, "the downside" of an otherwise joyful profession.

How to act in an often unexpected tragic situation was neither easy nor self-evident to the students. They learned that midwives should not break down in tears when their efforts fail; on the other hand they were "not robots," as one of the students said. Again, the primary norm was to support the parents, explain, and provide care. The midwife should be calm and controlled while in the delivery room – but she should be able to share her feelings of grief afterwards with her colleagues if necessary, away from the delivery room.

Again, the norm about the normal birthing trajectory applied, even in this abnormal situation. The students had to understand stillbirths as "normal" situations in childbirth, and one in which they should nonetheless work towards a normal birthing trajectory as much as possible. Vaginal birth is, even in these situations, considered the most desirable birth. The students also learned to talk of the woman and her partner as becoming parents at the moment of birth, even if the baby is born dead. They become parents – and at the same time parents who have lost their child.

The purpose and problem of norms

Norms are needed because they facilitate midwives' carrying out their work and upholding safety within delivery care. They help midwifery students to recognize normal birth and possible deviations, and act in the right way. Thus, they learn a collective approach to the situations and patients they will encounter in their coming profession. For example, they learn what Mäkitalo (2012) calls *categorization practices*, i.e. how to categorize situations and patients as midwives do. Even though personal variation between midwives is allowed, the professional norm seems to be that midwives should act and appear alike in practical situations. They should be able to take over from one another when a new shift comes in. This provides an important backdrop to why the midwifery students spent so much time on negotiations about norms and why they tried to find common approaches to how midwives ought to act; the professional midwife is in that sense a standardized practitioner.

This ideal of a common approach to one's work, of not standing out and of being replaceable, and as part of how the students are socialized into the profession, can, however, be seen in a different light. Based on examples from midwifery care in Australia, Myra Parsons and Rhonda Griffiths (2006) argue that the socialization processes that midwives undergo affect their decision-making ability. Their point is that midwives have learned to obey, first during their previous work as nurses and later in relation to their supervisors. Thus, their socialization undermines the ideal that a midwife is meant to be able "to practice autonomously." Parsons and Griffiths claim that there is a risk that midwives will not dare to challenge traditional practices in a ward, even if they go against evidence-based research. Learning the established norms is necessary for midwifery students entering the profession – but these norms may not be indisputably good, as they may prevent a desired development of how to practice midwifery.

Parsons' and Griffiths' argument is also relevant for my study. On the one hand, the students do not have that much choice; they must learn to perceive the world as other midwives do, which basically means accepting that pregnancy and birth are seen as normal processes in life, in which the

midwife offers the woman support. One could also raise questions about how safe delivery care could be upheld if midwives were not expected to do and act in the same way and thus, in a sense, be exchangeable. But on the other hand, it is important to question the conformity that midwifery students might learn. As the international comparisons mentioned in my study show, there are other ways for midwives to encounter birthing women and labor processes, and probably also a variety of approaches within Swedish delivery wards. The kind of problem-based training that the students receive encourages discussion and reflexivity about different experiences – but also tends towards finding consensus and the “proper” way to approach work.

Relevance and generalization

My study has focused on learning situations in which midwifery students came together as a group to discuss how to handle different situations as midwives and to reflect upon the proper professional attitude towards both patients and deliveries. I have shown how various feeling norms were tested out, accepted, or rejected in the students’ narratives and dialogues with each other.

How relevant are my findings from the students’ discussions for a more general understanding of norms within Swedish midwifery today? In Chapter 3, I used terms used by Golden-Biddle and Locke (1993) to discuss aspects of authenticity, plausibility, and criticality in order for an ethnographic text like the present one to be convincing. Authenticity concerns capturing the voices and perspectives of the informants. Plausibility is about showing clearly how the analysis and interpretations have been made, and criticality refers to getting the reader to reflect upon his/her own taken-for-granted perceptions and analyses of the topic involved.

Another way of looking at the plausibility of a qualitative study is to see it as a form of generalization. As educational researcher Staffan Larsson argues, “generalization is an act, which is completed when someone can make sense of situations or processes or other phenomena with the help of the interpretations, which emanate from research texts” (Larsson 2009: 34).

To achieve this aim, Larsson writes, the researcher should attempt to maximize variation, strive for context similarity and allow for recognition of patterns (2009: 28ff).

Maximizing variation is about showing the variety of contexts in which something has been discussed, as a way to avoid the risk of some voices not being heard. In my study, I have focused on a very specific type of education and observed a limited group of people. However, I have been attentive to the variety of situations that the students addressed as relevant for their future work. I have also based my analysis on the variety of school-based settings that they were involved in and on voices from all the students involved, and analyzed norms and emotions involved in both “normal” and “complicated” birthing situations.

I would argue that the norms discussed were both specific for the groups I observed, and reflect and relate to more general norms within midwifery. For one, the discussions studied build upon educational material presented during their education as well as on what midwives had told the students during their practical training. The students included all of these in their discussions about how, for example, to support women with excessive fear of childbirth. The norms also reflect standard practices within Swedish midwifery today. Research by Hellmark Lindgren (2006) and others has shown that vaginal birth – which the students seem to take for granted as the desired outcome – is in Sweden seen as involving the lowest degree of risk, and thus is the preferred form of delivery. However, this may not always have been the case, as shown in the research by Jansson (2008). She has analyzed how Swedish delivery care has changed over time, and how perceptions of risk concerning vaginal birth and caesarean section differ, depending on context and time.

That childbirth should take place in a hospital is also a culturally constructed notion, prevalent in Sweden. The fact that the concept normal birth differs between times and places is shown by researchers including Akrich and Pasveer (1998, 2004) in their comparative study of birth practices in France and the Netherlands. They analyze how notions of risk in childbirth shape the perception of normal birth, either as something that demands

technological monitoring and pain relief or as something that women can handle with just the support of a midwife, and which can be done at home.

These observations relate to what Larsson calls *context similarity*, which he sees as a way to achieve generalization by situating one's study in the context of other, similar studies. I have related my study to what has been discussed in previous research about midwifery work and education, discussed similarities and differences, but also noted where these studies support my results.

In addition, by relating to previous research about emotions in gendered caring professions, this study also contributes to some larger theoretical and methodological issues. This is done, I would argue, by *recognizing patterns* and *elucidating the taken-for-granted*, which is the third way of reasoning about generalization presented by Larsson.

This study has prepared the way for an analysis of norms-in-the-making. This differs from previous studies of professional attitudes that focus on existing rules and norms, and do not explore how these are negotiated and learned as part of learning a profession. By bringing together concepts from sociology, anthropology, and education, I have analyzed how a collective way of understanding a profession, but also how the patient, her medical and emotional background and life situation, are being shaped within education. Concepts such as categorization work, feeling norms, and predictive markers have been developed in this study to find patterns and elucidate the taken-for-granted norms within this, and possibly also within other professions and situations.

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