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### 'Navigating the self in maternity care: how Chinese midwives negotiate their individual professional identity in hospital settings?'

A Grounded Theory Analysis of Chinese Midwives' Professional Identity

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## **Navigating the self in maternity care: how Chinese midwives negotiate their individual professional identity in hospital settings?**

### **Abstract**

The professional development of midwifery in China has been challenged by a medical dominance within midwifery policy and practice over the last 60 years. It is argued that such a challenge may lead to a sense of identity crisis for the profession, and this has become particularly salient since midwifery practice was confined into hospital settings and midwifery became a sub-branch of the nursing profession over the last two decades. Against such a backdrop, in order to understand how Chinese midwives negotiate their individual professional identity in hospital settings, this paper draws upon findings from a Constructivist Grounded Theory study that explored the professional identity construction of the Chinese midwives within the hospital settings of a capital city in Southeast China. The accounts from 15 midwife participants in the form of in-depth individual interviews were digitally recorded. Work journals from three midwife participants were also included. The study indicated that in everyday practice, hospital midwives were negotiating their individual professional identity in relation to two competing identities: the 'obstetric nurse', bound up to the risk management under the medical model in their work organisation; and the 'professional midwife', associated with the philosophy of 'advocating normal birth' in the professional discourse. Six strategies for identity work were identified and grouped into two principle categories: 'compromise' and 'engagement'. The adoption of each strategy involved a constant structural and attitudinal interplay between the internal and external definitions of the midwife, resulting in a 'hybrid identity'. The strategies for identity work and the resultant hybrid identity revealed in this study may help hospital midwives to get a better understanding of their professional orientation and the external constraints, and facilitate engaging in a practice that is consistent with their professional ideals.

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*Keywords:* Mainland China; Hospital-based Midwives; Identity Crisis; Identity Work; Medical Dominance; Midwifery Discourse.

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## **Introduction**

Because of the medical dominance in midwifery practice around the world, this profession has been involved in a constant debate about how to define itself (Annandale and Clark, 1996), and what constitutes practitioners' professional identity (Lane, 2002, Hunter, 2004, Davis-Floyd, 2007). As has occurred in many other countries, the medical dominance within midwifery policy and practice in China has brought about a sense of crisis of midwifery identity within and outside the profession (Harris et al., 2007, Harris et al., 2009, Cheung, 2009, 2011). The identity crisis has become particularly salient since midwifery practice in China was confined into hospital settings and Chinese midwifery became a sub-branch of the nursing profession over the last two decades (Harris et al., 2007, Cheung, 2009, Tan, 2010). The concern of the identity crisis for Chinese midwifery promoted the present study to explore how Chinese midwives negotiate their individual professional identity in hospital settings. The concept 'identity work' underpinned by the perspective of identity politics offered valuable insights into the understanding of the strategies midwives adopted to negotiate their professional identity at work.

### ***Identity Crisis of the Profession: Medical Dominance***

Midwifery in China traditionally followed a 'holistic' philosophy of care, having its root in the traditional Chinese concepts *yīn* and *yáng*, which emphasises "the balance of the mind, body, spirit and soul as a whole" (Cheung, 2011: 213). This 'holistic' approach to childbirth is, to certain extent, analogous to the midwifery/social model, which situates childbirth in a social, cultural, spiritual and natural setting and demonstrates a woman-centred approach (Page, 2003, DeVries, 2004, Downe, 2004, Van Teijlingen, 2005). Since the professionalisation of Chinese midwifery in the 1920s (Chinese Ministry of Health, 1928), the traditional midwifery approach has been reconstructed through a biomedical training with a more specific focus on the technological aspects of the biomedical model, being greatly influenced by Western medicine and technology (Cheung, 2009, Harris et al.,

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2009, Johnson, 2011). Within such a model of care, birth is treated as a risky event while midwives are required to monitor and manage birth based on the 'normal' standards that are defined by the medical authorities (DeVries, 2001, Robertson, 2002, Harris et al., 2007). This kind of biomedical professionalisation has enabled medical monopoly within midwifery policy and practice (Cheung, 2011: 296), while also has undermined the meaning of being the 'holistic' midwife.

Particularly with the Chinese modernisation campaign in the 1980s ('reform and opening up' **will be explained in footnote**) (Deng, 1984), the biomedical science has become a symbol of Chinese modernisation; whilst the medical model has been readily adopted by state authorities (Cheung, 2009), leading to the medicalisation and hospitalisation of childbirth throughout China (Barclay, 2008, Cheung, 2009). As a consequence, midwifery care has been dominated by the medical model; whilst the sphere of midwifery practice has been confined to hospital settings and the majority of the hospital midwives' practices have been narrowed down to intrapartum care over the last twenty years (Harris et al., 2009). With regard to structural relations, the hospital is viewed as the epitome of powerful medical influences, where medical norms are predominant and midwives are often given a position as obstetrician' assistant (Purkis, 2006, Harris et al., 2007). In the hospital settings, Chinese midwives may be more likely to be assimilated into the philosophy of childbirth that is based on the medical model rather than its previous holistic approach. Such an attempted assimilation can lead to challenge and struggle over the nature of midwifery and an identity crisis for the midwifery professionals becomes perceptible (Cheung et al., 2009). The sense of identity crisis has been aggravated when midwifery was categorised as a subset of the nursing profession in the early 21st century (Cheung, 2011), as this suggested that not only has the nature of the midwifery profession been chipped away at but its professional status within the healthcare system has been equated with an obstetric nursing (Harris et al., 2007, Cheung, 2009, Tan, 2010).

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### ***Theoretical Basis for the Profession: Midwifery Discourse***

Chinese midwives have been expressing their desire to demonstrate the uniqueness of midwifery care in order to maintain role security and to retain their professional status (Cheung et al., 2009, Cheung et al., 2011). However, in order to demonstrate the uniqueness of the profession there is a need to be clear about its theoretical basis. The international studies that evidence the importance of the midwifery model present a counter-discourse to one of medical dominance (Hatem et al., 2008). Such midwifery discourse serves as a theoretical basis for the midwifery profession worldwide linked to retention of professional autonomy and professional status (Sandall, 1995). In China, with the support of the midwifery discourse from international communities, some midwifery initiatives were launched with an attempt to retrieve the holistic philosophy of midwifery care and revive the profession. At the professional arena, a midwife-led normal birth unit (MNBU) was developed in Hangzhou in 2007 (Cheung et al., 2009, Mander et al., 2010), which now acts as an exemplar for midwifery services in China, demonstrating the value of midwifery care and advocating the profession. With the support from the Chinese Ministry of Health, the Chinese Maternal and Child Health Association (AMCHA) (2010) initiated a five-year (2010-2014) demonstrative project "promoting natural childbirth, safeguarding the wellbeing of mother and baby". One of the project objectives is clarifying the midwives' professional role.

With budding support from both the state and the academic bodies, the midwifery discourse has begun to exert its influence on Chinese midwifery. This resurgence of interest in the midwifery model serves as a theoretical tenet for the organisation of the identity of the midwifery profession and delivery of midwifery services. However, the medical discourse has continuously dominated maternity care over this period with an emphasis on risk management and cost-effectiveness (Cheung, 2011), whilst there is no clear guidance on what the midwife's role means in the Chinese maternity system to date. For the hospital midwives, if they are either not clear about the

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theoretical underpinnings of their professional role or unable to enact them in practice, the sense of identity crisis would continue to exist.

### ***Identity Work***

Previous studies suggest that in facing of specific events or experiences, such as an identity crisis (Costello, 2005), 'identity work' is likely to be triggered. The term 'identity work' has appeared occasionally in the broader literature in social science (Watson, 2008), and is used to describe the act of the 'agency' in the process of identity formation. In organisational studies, this concept has been formally referred to as a continuous process of 'identity creation, regulation, negotiation and modification' (Adams and Crafford, 2012: 2), which emphasises the individuals' engagement in: "forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness" (Sveningsson and Alvesson, 2003: 1165). To raise the awareness of the influences social context can exert upon identity work, Watson (2008) reconceptualises this concept by carefully balancing and settling the tensions between the self and the external categories denoted by the social context.

Along with its conceptual development, a number of theoretical perspectives on the strategies in identity work have evolved. One area of identity work research pertaining to this study is underpinned by identity politics, which associates the declaration of a distinct and positive identity with empowerment of individuals as well as the social group (Costello, 2005). The origin of identity politics stems from the concern that one's personal or group identity is constructed within a social structure where the identity is defined by the dominant others. Classically, the issues are related to the characteristics of personal identity, such gender, race, class and nationality, e.g. (Crenshaw, 1991). The most explicit example is reflected in feminist studies that view the identity of women as defined within a dominant male culture. Similarly, midwifery has frequently claimed that its identity is moulded by the

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institutional culture dominated by medicine. Such establishment of identity was defined by Castells (2004: 8) as 'legitimising identity'; through which the institution attempts to rationalise the role allocated to the professions and the power relations between them.

Castells (2004) also contends that any social construction concerning identity will take place within the context of power relationships. Where individuals are devalued or stigmatised by the dominant groups, resistance to this control and dominance can be evoked. This is identified by Castells (2004: 8) as 'resistance identity'. This may be reflected in current Chinese midwifery through the profession claiming to legitimise and officialise its distinctive identity, with the aim of establishing independence from the definition determined by the medical profession. However, 'resistance identity' has been viewed as merely a form of reactive response to the category dictated by the dominant social structure, while the internal interpretations of the subordinate group are still confined by the external definition (Payne, 2006). The more effective approach is to enact resistance identity in order to change the social structure. This is what Castells (2004: 8) terms as 'project identity': when individuals deliberately employ available cultural and social resources in order to construct a new identity, seeking 'the transformation of overall social structure'. In relation to the contemporary development of midwifery in China, such transformation may be seen in the initiatives the profession is undertaking in an attempt to re-establish its training, and restructure midwifery practice, based on the midwifery model.

In the writings on professional identity inspired by identity politics theory, professional identity is viewed as: "something that must be 'claimed' in a political/personal 'struggle' against stereotypes, as individuals and groups seek to 'construct' a 'usable' form of professional identity" (Costello, 2005: 32). With the concern of an identity crisis for Chinese midwifery, this study takes up the identity politics perspective of professional identity to explore how Chinese midwives negotiate their individual professional identity in hospital settings.



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## **Methods**

### **Design**

Considering the focus and type of the research problem that the current study aimed to address, the development of an explanatory theory from the views of the study participants was the primary objective of this research. It fits with the aim of Grounded Theory (GT) approach (Creswell, 2007). Due to my past research and practising experiences in maternity units, I acknowledged that, as a researcher, my interaction with the participants and my interpretation of the data at the later stage of analysis is part of the research process. My philosophical position in relation to this study is closer to Charmaz's (2006, 2008) constructivist version of GT approach, which is thus applied to guide this study.

### **Setting and Participants**

This study was conducted in a capital city of a province in the Southeast China. Following the principle of GT, participants were theoretically sampled. Fifteen midwives from three types of hospitals were recruited to explore their experiences in a mixture of working contexts, including one provincial maternal hospital (MH) and one urban general hospital (GH) in the central area of the city, and four small local general hospitals (LGH) in suburban areas. The description of the participants' work settings is presented in Table 1. Participants were largely representatives of the hospital-based midwives in terms of experience, types of midwives, position and working context (profiles of the participants are presented in Table 2).

### **Ethics**

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The primary ethical approval was obtained from the Ethical Committee at the University of Edinburgh where I am studying for a doctorate and the Academic Committee in Hangzhou Normal University of China where I work. Bearing in mind that accessing potential participants through relevant gatekeeper may influence the way in which the participants provide information (Orb et al., 2001), recruitment of the prospective participants was gained through personal contact. The informed written consent to participate in the study was given by all participants and the participants were assigned pseudonyms. Throughout the recruitment, only one participant from hospitals (LGH) refused. As she was transferred from nursing to midwifery for only three months, she believed that she didn't have enough midwifery experiences to share with me. The other participants whom I initially contacted all participated in this study. The underlying reason for the high response rate may be in that some of them were willing to talk to me because they wanted to share their experiences and make their voice heard, or the midwives, whom I knew before, have felt obligated to help me; while others may have felt authoritative pressure from their managers. Bearing such potential ethical issues in mind before the outset of the fieldwork, at the initial phone contacts I spent more time to explain the information of this study to the prospective midwives, assure them of their voluntary-based participation and carefully selected the interview time and venue to suit them. Before the interview, I clearly explained their right to withdraw from the study at any time without any harm, reassured them of the anonymity and confidentiality, and made effort to establish a rapport with the participants.

## **Data Collection**

Data were obtained between October 2010 and May 2011. In-depth interviews were used as a main method to collect accounts from the participants. The in-depth nature of this method fostered eliciting the views of the participants' subjective world and ensured the rich and dense data to be gathered (Charmaz, 2006). Through engaging in dialogue with individual participants, I was more able to follow their responses, go beneath the surface

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of their descriptions, probe for more details, and facilitate their reflections; thus enabling collection of rich data. In addition, due to the busy shifts of the midwives, individual interview was feasible for the present study. With the goal of understanding midwives' professional identity negotiation, the interviews focused on the experiences, incidents, opinions, and values of respondents. Interview topics were developed from and continuously revised during the GT process. All interviews were conducted in Mandarin. The choice of date, time and location for interviews was proposed by the participants for their convenience. Fifteen interviews were conducted and audio-recorded. Each lasted an average of one hour. Apart from the interviews, work journals were voluntarily provided by three midwives (Emma in GH; Juliet in MH, and Jenny in LGH). These written documents deepened the insights into the midwives' interpretations of their professional identity negotiation through their work stories and their reflections of these stories.

Grounded theory is developed through constant comparison of data obtained from theoretical sampling, which gives this methodological approach its analytic power and grounds the developed theory in the data (Charmaz, 2006). At the initial stage, Glaser (1978: 45) suggested that researchers 'go to the groups which they believe will maximise the possibilities of obtaining data and lead for more data on their question'. By this means, five midwives (Catherine, Linda, Emma, Emily and Juliet) from two hospitals (GH and MH) were drawn purposively at the beginning of the fieldwork. Through these interviews, the quality of initial data collection and analysis were examined by academic supervisors. The initial data informed the generation of a range of raw categories, which directed my further theoretical sampling. For example, the category 'compromise' guided me to explore various strategies of compromise adopted by individual midwives with different midwifery experience and from different working context. I thus further recruited midwives from the hospitals (LGH) in suburban areas, and midwives with different years of experience to expand the properties and dimensions of the category. Following this principle,

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later sampling continued to develop and intensify these categories until no new properties pertaining to the research inquiry were revealed from the newly gathered data (Charmaz, 2006).

## **Data Analysis**

The analytical process started with transcription and review of the first interview. Constant comparison and memo writing were conducted throughout the study to assist the analytical process. There have been different opinions regarding coding process among GT approaches. The major debate is the choice of the coding procedures between Glaser's (1978) and Charmaz's (2006) two-step approaches (the substantive and theoretical coding or the initial and focused coding) or Strauss and Corbin's (1990, 1998) three-step approach (open, axial and selective coding). For this study, Strauss and Corbin's (1998) more explicit coding procedure (open coding, axial coding and selective coding) was considered pragmatic to guide a novice GT researcher to conduct the data analysis. Rather than adhering to this coding procedure rigidly, I used it as a guideline that was open to be adapted to the research context. In keeping with the GT approach, narratives in the work journals provided by the three midwives were analysed through the same coding procedure as the interview transcripts were processed. This method of analysing narratives was termed by Polkinghorne (1995: 13) as 'analysis of narratives'; using narratives as data and 'seeking to locate common themes or conceptual manifestations among the data'. Given the cyclical nature of GT approach, while the coding processes are presented sequentially in the following text, these occurred iteratively in practice.

Open coding was the initial stage, at which the data was broken down into units, was labelled, conceptualised and compared with similarities and differences (Strauss and Corbin, 1998). The stage of open coding involves the development of categories through a process of classifying and categorising concepts. By this means, 'events, happenings, objects, and actions/interactions' that shared similar characteristics and meanings in nature were

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merged into the more abstract concepts named as 'categories' (Strauss and Corbin, 1998: 102). During the classification and categorisation, the open codes were grouped into fourteen conceptual categories.

Once the important categories were identified, the next step was to develop them by defining their properties ('the general or specific characteristics or attributes of a category') and dimensions ('the location of a property along a continuum or range') (Strauss and Corbin, 1998: 117). This stage is termed by Strauss and Corbin (1998) as 'axial coding'. Corbin and Strauss (2008) acknowledged that 'categorisation' (at the open coding stage) and 'axial coding' were separated only for explanatory purpose. In practice, the two processes often merge together, as happened to this study: axial coding began when certain categories developed from the analysis of the initial five interviews, which enabled the development of the subsequent categories and the relationships around 'the axis of a category' (Strauss and Corbin, 1998: 125). During axial coding, fourteen conceptual categories were grouped into six principle categories: 'institutional position', 'organisational management', 'professional discourse', 'compromise', 'engagement' and 'hybrid identity'.

Selective coding is the final step of the coding process. This process involves 'integrating and refining categories', as well as identifying the 'central category' that has the ability to integrate all other categories to develop an explanatory story (Strauss and Corbin, 1998: 143). In this final stage, the core category was identified as 'navigating the self in maternity care', which was central to all other categories and linked them together. It suggested that in the hospital settings the individual midwife was navigating on an identity continuum with one end being 'obstetric nurse', to 'professional midwife' at the other.

NVivo 8 was used to manage the data. All interviews were fully transcribed in Chinese and the original data was analysed in Chinese at the open coding stage. The codes and the quotations from the open coding were then

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translated into English by the first author. The consistency was checked by a bilingual colleague. The subsequent analysis was discussed with academic supervisors to identify and confirm the main categories and emerging theoretical model.

This paper discusses three principal categories of the findings: 'compromise', 'engagement' and 'hybrid identity'

## **Findings**

This study found in everyday practice, the hospital midwives were negotiating their professional identity in relation to two competing identities: the 'obstetric nurse', bound up to the risk management under the medical model in their work organisation; and the 'professional midwife', associated with the philosophy of 'advocating normal birth' in the professional discourse. The characteristics of the competing identities are summarised as follows:

'*Obstetric nurse*' in this study refers to the midwife who is subject to the organisational categorisation of an obstetric nurse. These midwives' work complied with the organisational priority of reducing risk. They rigidly followed the protocols and unwritten rules that are prescribed by the medical model. Their professional autonomy was largely limited under obstetricians' supervision.

'*Professional midwife*' in this study refers to the midwife who is kept to the professional identification of an autonomous midwife. These midwives' work priorities are in accordance with the professional ideology of advocating normal birth. They worked in collaboration with obstetricians and were more flexible in their practice, and endeavoured to tailor the rules and conditions to meet women's needs.

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Six strategies in identity work were identified and grouped into two principle categories: 'compromise' and 'engagement'. Each strategy that individual midwives employed drove them either towards being an 'obstetric nurse' or, alternatively, progressing towards being a 'professional midwife' to varying degrees. Revealed in the study, individuals often employed more than one strategy to negotiate their professional identity at work. The adoption of each involved a constant structural and attitudinal interplay between the internal and external definitions of the midwife, being influenced by midwives' experiences, relationships with women, opportunities for professional development and the definition of the situation. As a consequence, the individual professional identity was actually constructed in a dynamic process, navigating along an identity continuum between 'obstetric nurse' and 'professional midwife' at opposing ends, leading to a 'hybrid identity'. The three principle categories are interpreted and presented diagrammatically in Figure 1.

## **Compromise**

Compromise refers to the strategies midwives employed to attempt a compromise with the risk management under the medical model in their work organisation.

### **Settling the Self on the Work Role**

When everyday practice was repressed by the medical power in the work organisations, the common strategy that midwives adopted was to settle the self on the work role whilst leaving professional ideology aside for the moment.

Midwives concurrently claimed to be the professional who advocates normal birth. However, data suggests that the midwifery service was located in the system where childbirth was bound up with the culture of risk and medical

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power. Their everyday practices were regulated by the medical protocols. If these were by any means broken, they would 'be responsible for any adverse event' (Juliet MH). In an attempt to offset the stress in relation to the 'risk concerns' of potential litigation, the action that midwives often undertook was to acquiesce in the medical protocols. As Juliet commented:

*However, in hospital many of our practices focus on avoiding the potential risk of the poor outcome, like giving interventions beforehand. I know some of them [interventions] are unnecessary. However, we must follow them, as long as woman and baby are safe. It is a kind of unwritten rule. We need to follow. (Juliet (MH))*

Such compromise strategies have echoes of Lipsky's (1980) analysis of the street-level bureaucrats. Under the practical constraints, the common strategy that front-line public service providers adopt is to exert their constrained discretion to pragmatically manage the competing role expectations at work. For midwife participants in this study this means having to practise against their professional values at times.

### **Detaching the Self from Professional Ideology**

Detaching the self from professional ideology for self-protection was another strategy that some midwives adopted in an attempt to reconcile their 'risk concerns' related to the women's reliance on medicalised birth.

In practice the 'risk concerns' pertaining to the potential legal dispute from the service users has at times triggered midwives' choice of self-protection. Some midwives suggested under the pressure of women's reliance on medicalised childbirth, sometimes they intended to give up their responsibilities to the obstetricians, as Anne indicated:

*The risk is high in the obstetric unit. The dispute with service users happens quite often here. Some women are hard to communicate with now. When labour starts, they scream for a caesarean. If not, we must promise to guarantee the health of them and their baby. In cases like this, we usually ask doctors to talk to them. If the doctors agree to give surgery, we*



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*prioritise the doctors' decision ... as in the hospital, doctors manage childbirth. Our care is mainly based on their orders. (Anne (LGH))*

In order to relieve the risk concerns originated from the consumerist confrontation for the midwives' warranty of the health of the mother and baby, some midwives appeared to disengage themselves from their professional ideology of advocating normal birth.

### **Immersing the Self into Work Ideology**

For some other midwives, they seemed to allow themselves to be immersed into the work ideology without consciously feeling the conflict.

In the medical view, childbirth is commonly considered as a potential risk until the condition of the woman and baby is confirmed otherwise (Percival, 1970, Wagner, 1994). Analysis in this study has revealed that such medical views have played a dominant part in defining what the appropriate midwife's role should be. Being trained and working under the obstetric-led model, some midwives seemed to take in such medical views without consciously feeling the conflict. Taking Mary's account for example:

*In my opinion, it is almost impossible to have non-interventional childbirth. From my experience, I feel the average of the labour process just becomes abnormal, either too fast or too slow [according to the 'normal' time frame of childbirth]. Only a few women give birth normally. (Mary (MH))*

By conforming to the medical standards of 'normal' birth, midwives like Mary were apt to apply such medical views to their practice. They employed the medical standards to observe, evaluate and monitor the condition of childbirth. As a result, they were less likely to accept the variations involved in this normal physiological process.

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## **Engagement**

Engagement refers to the strategies midwives adopted to engage their practice in the professional discourse of 'advocating normal birth'.

### **Enacting the Midwife Role Whenever Possible**

Enacting the midwife role whenever it is possible was the common strategy that midwives employed to fulfil their professional discourse in practice. Such an engagement strategy was often used by the midwives who had chosen to settle on the work role for the moment under organisational control. When it is possible, these midwives would try to eschew the medical protocols to pursue the role of advocating normal birth.

With the support of midwifery discourse, midwives were equipping themselves with the normal birth knowledge and skills, which helped to enhance their beliefs and competence in advocating normal birth. The study revealed that the midwives, who were competent in their midwifery knowledge and skills, were more likely to make an effort to sustain their normal orientation. These midwives were identified as those who have years' experience of working outside of hospital settings, like Jenny; and those who have practised in the workplace influenced by the midwifery model, such as Daisy.

*Sometimes, I find I can keep things normal, when doctors are quite busy, especially during the night shift. (midwife, Jenny (LGH))*

*If we want to play a midwife's role to keep things normal, the midwife-led room is a better place to work. Normally, we can keep the obstetricians away from there. (midwife, Daisy (GH))*

However, bearing in mind the current dominant power of the medical model, these midwives decided not to confront the medical power and challenge the authoritative obstetricians directly; rather they sought to perform

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their professional role fully on the night shift and to keep the obstetricians away. Similar forms of practice employed by the hospital midwives in the UK were known as 'doing good by stealth'; by which these midwives aimed to deal with the oppressed intra-group culture permeated with 'service and sacrifice' (Kirkham, 1999: 736). Other than coping with the oppressed culture within the midwifery group as these UK midwives did, midwives in this study used such devious behaviours to achieve their professional goal under the current organisational management.

### **Building Alliances with Women**

Midwives acknowledged that women's support was of significance in sustaining their professional identity and midwifery profession. Making alliances with women in care provision was another strategy that midwives used to negotiate with the organisational management in order to engage in their professional ideology.

As a way to negotiate with the medical protocols, most midwives have tended to ally women by taking opportunities to keep women informed about the negative effects of medical interventions, as Yvonne did:

*I saw the women with medical induction feel much more pain than in normal labour, because the body is not ready ... they are more likely to ask for a caesarean during labour ... So when I cared for the women, I tried to remind them of the outcome, like 'you need to think thoroughly, induced labour will become very painful later. (Yvonne (GH))*

The alliances with women were more likely to be established in hospital GH, where there is a midwife-led labour room in operation. By providing sufficient and effective information, midwives were more able to increase women's confidence in their ability to give birth normally. Taking Emma's experience (quotes from her work journal) as an example:

*I worked with her and explained every move of her birth with a pelvis model. While explaining every detail to her, I helped her to trust her own body. When the doctor showed up and*

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*planned to give her oxytocin, she asked for more time. It encouraged me to work with her ...*  
(Emma (GH))

Emma's words indicate that successfully allying with women clients has enabled midwives to better negotiate care with the medical protocols and the obstetricians.

### **Shaping the Organisational Context**

More explicit engaging strategy that midwives adopted is in shaping the organisational context. Midwife managers in GH have introduced the midwifery model into their unit by establishing a midwife-led labour room, which has created opportunities for midwives to enact the professional discourse and internalise these ideological constructs into their own ideology of practice. The on-going professional development in the midwifery model was deemed a vital means of helping to reinforce for midwives the distinctiveness of their professional identity in relation to their knowledge, skills and role. Engaging in such community of practice has encouraged and empowered these midwives to shape the organisational context where they worked.

*I brought the knowledge I'd learned from the midwife-led unit to the traditional labour ward, such as how to breathe, keep relaxed and cope with the labour pain, change to a comfortable position during labour and birth. When I internalise this knowledge into my own ideology, even when still under the medical model, I feel more able to fulfil my role. (Fiona, (GH))*

The experience of working in the midwifery model has enabled the midwives in GH to exercise their agency in the face of the organisational structures. More importantly, these midwives' actions to enact their professional ideology have exerted an impact back upon the organisational management, as Linda (GH) commented, "*the whole working atmosphere is more humanistic now*". With the implementation of the midwife-led labour room, GH was the hospital where the midwives' negotiations with the organisational management appeared to be most explicit. It implies that although work organisations seem to exercise power to regulate the midwives involved, there is a possibility that midwives enact their agency to shape the organisational context.

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## **Hybrid Identity**

The study found that individual midwives often employed more than one of the above strategies. The most commonly used coping strategies were 'settling the self on the work role' and 'enacting the midwife role whenever possible'. The majority of the midwives appeared to move between the two strategies at times, being influenced by the situation and the experiences of the midwives. The use of these two seemingly contradictory strategies reflects midwives' attempts to retain both of their internal ('professional midwife') and external ('obstetric nurse') definitions.

Some midwives attempted to protect themselves from potential legal disputes by 'detaching the self from professional ideology'. Such coping strategy indicates midwives' intention to take on their external definition ('obstetric nurse') by disengaging the central tenet of their professional identity. Other midwives consciously negotiated with organisational control by 'building alliances with women'. Such engaging strategies manifest midwives' agency in resisting their external definition ('obstetric nurse') by aligning with significant others. The adoption of each strategy was related to midwives' relationships with women.

The midwives, who practised purely in medical-technical contexts without participating in professional development activities supported by midwifery discourse, were likely to 'immerse the self into work ideology'. These midwives were at risk of losing their professional sense of the self by taking in their external definition ('obstetric nurse') unconsciously. For others, the experiences of engaging in the midwifery model offered opportunity for them to 'shape the organisational context'. These midwives appeared to internalise the professional

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discourse into the self through engaging in a substantive change to the organisation structure. The adoption of each strategy was influenced by their opportunities for professional development.

On the whole, these varying strategies that midwives adopted to negotiate their professional identity at work suggest that individual midwives was constructing their professional identity in a dynamic process. With the influence of their experiences, relationships with women, opportunities for professional development and the definition of the situation, in daily practice individual midwives seemed to keep adjusting themselves between the internal and external definition of the midwife. They, therefore, were navigating along an identity continuum with 'obstetric nurse' at one end and the 'professional midwife' at the other, resulting in a 'hybrid identity' (See Figure 1).

## **Discussion**

The competing categories of being a midwife between the midwifery profession and the maternity care organisation and the consequent subjective discomfort have been recognised by many hospital-based midwives in different countries (Hunter, 2004, Foley, 2005, O'Connell and Downe, 2009, Purkis, 2006). On the basis of Festinger's (1957) cognitive dissonance theory, Costello's (2005) has theorised such uncomfortable experience as 'identity dissonance'. This study suggests that within the medically dominant hospital settings the midwives' experiences of identity dissonance are inevitable and will continue exist, particularly for contemporary Chinese midwifery with its subordinate 'nursing' position in the maternity care system. It requires midwives to constantly negotiate their professional identity at work. The strategies for identity work and the resultant hybrid identity revealed in this study may help hospital midwives to get a better understanding of their professional orientation and the external constraints, and facilitate engaging in a practice that is consistent with their professional ideals.

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Compromise can be seen as a common strategy of avoidance from the cause of conflict, as it seems to be an easier way for midwives to 'conform than to work against' the system (O'Connell and Downe, 2009: 600). Encountering the conflicting requirements from the work organisations and the profession, the coping strategy of 'settling the self on the work role' for the time being is in accordance with the common identity work of refusing to make choices by realigning the conflict identities (Costello, 2005); while the strategy of 'detaching the self from professional ideology' is akin to the identity work of adopting the identity of the dominant social structure (Costello, 2005). The findings are reminiscent of hospital based midwives in many other countries (Finlay and Sandall, 2009, O'Connell and Downe, 2009): for example, the 'with institution' midwives in Hunter's (2004: 261) study on emotional labour and the prescriptive midwives found by Bluff (2003). Such compromise may have enhanced the power of the dominant social structure at the cost of keeping midwives in a marginal status. It is noteworthy that in this study some midwives seemed to be immersing the self into the work ideology without consciously feeling the dissonance. The way that these midwives unconsciously took in the medical view has evidenced the 'cultural imperialism' (Young, 1988) of the medical profession in this study context. As the values of the medical group have become the norm, the subordinate midwifery group is likely to be acculturated into the medical way of being and fail to recognise its own value, particularly when the medical norms are policy oriented in this research context. Such compromise puts midwives at the risk of losing their own professional identity and detracting from their professionalisation.

The study found being facilitated by the professional discourse, midwives were involved in a range of their own professional development activities to learn, strengthen and apply their professional ideology into practice. Such engagements have served as a powerful resource for professional identification, enabling midwives to negotiate with the medical dominance. The engaging strategies 'enacting the midwife role whenever possible' and 'building

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alliances with women' are consistent with the identity work of consciously resisting the identity that dominant social structure entails (Costello, 2005). These strategies echo what Lipsky (1980: 14) has suggested; in order to practise in more professionally acceptable ways, the 'street-level bureaucrats' attempt to resist the organisational structure by creating their own working 'rules'. It is reminiscent of some studies in midwifery literature, particularly Rosser's (1998) 'breaking the rules', Hunter's (2004) 'with women' ideology and what Kirkham (1999: 736) termed as 'doing good by stealth'. However, as Kirkham (1999: 736) pointed out, since 'both the aims, and the activity itself are concealed', midwives can only be able to achieve marginal professional success. In the current study, an explicit engagement strategy is 'shaping the organisational context', which was acted out through the application of a midwifery model in the study site (GH). It has created opportunities for some midwives to learn, reinforce and identify with the professional essences. Learning through participation in the practice of a community has been systematically analysed in the work of Wenger (1998). Although in this study midwives' engagement in the form of community of practices was largely implicit, it is through the on-going professional learning and practices that these midwives have gained a sense of who they are and what they are competent at doing.

The study found that the construction of individual midwives' professional identity was navigating along an identity continuum with the external definition 'obstetric nurse' at one end and the internal definition 'professional midwife' at the other, thus giving rise to a 'hybrid identity'. The findings, though based in the context of China, could go some way to supporting Davis-Floyd's (2007: 705) interpretations of the 'postmodern' midwives or Lane's (2002: 26) descriptions of the 'hybrid' midwives in the broader settings. However, either Lane's (2002) 'hybrid' midwives or Davis-Floyd's (2007: 705) 'postmodern' midwives implies that midwives' blending practices are grounded in the individuals' own way of understanding midwifery care, which has become their own ideology that guides practice and formulates an individual's professional identity. Differently indicated in this study,



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although midwives' pragmatic decisions were largely made on their own, these were in part the product of their marginalised position in the maternity care system. In the current state, what is valued by the midwifery profession at times deviates from the central function of the maternity care system. As a consequence, other than framing their professional identity on the basis of individuals' own values, the strategies 'settling the self on the work role' and 'detaching the self from professional ideology' reflect midwives' powerlessness in claiming the ownership of the meanings underlying their profession.

## **Conclusion**

As the current study was conducted in a specific geographical area of China, findings could not be generalised to wider context without any problem. However, the exploration of the strategies in hospital-based midwives' identity work and the resultant hybrid identity has the potential to make theoretical inferences in similar settings. Further studies could be conducted in other geographic areas across China and in hospital settings in rural areas to test if the findings are reflective of the views of midwives in other contexts. As indicated in this study, the consequence of the identity work, a 'hybrid identity', may offer temporary alleviation to the identity dissonance. However, if midwives exert no substantial influence, the profession will be continually in a state of identity crisis. The danger would be seen as the consequence of the 'bad faith' (O'Connell and Downe, 2009: 605) that midwives immerse themselves into the position, values and ideology defined by medical profession and ultimately neglect the very essence of being a professional midwife. One resolution that demonstrated its significance in this study is the role of the continuing professional development supported by midwifery discourse, which was viewed as essential for midwives to progress towards the 'professional midwife' end of the identity continuum. Further research should consider the content and forms of continuing professional education in order to facilitate midwives to pursue their professionalisation in serving women and society.

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## Table

Table 1 Summary of the Working Context

Name	Average Number of Births in 2010	Number of Midwives in 2010	Characteristics of the Hospital
Maternal Hospital (MH)	10,000	50	A specialist maternity with five maternity wards, one labour ward and one neonatal intensive care unit. Maternity care is operated under an obstetric-led model.
General Hospital (GH)	6,000	42	A general hospital with three maternity wards and one labour ward in the obstetric department. Maternity is mainly operated under an obstetric-led model, while a midwife-led labour room is implemented.
Local General Hospital (LGH)	2,500	10	Local general hospitals located in the suburban area. Obstetrics and gynaecology departments are not separate. Maternity care is operated under an obstetric-led model. The midwives occasionally work in gynaecology wards.

Table 2 Profiles of the Midwife Participants

Hospital	Name	Post	Educational Background	Employment before Midwife (years)	Years of Midwifery Practice
TMH	Emily	MM	Midwifery	—	25
	Juliet	—	Nursing	GN(1)	3.5
	Mary	—	Nursing	ON(5)	4
	Lena	—	Nursing	—	3
TGH	Catherine	MM	Midwifery	—	36
	Linda	MM	Midwifery	—	26
	Emma	—	Midwifery	—	3.5
	Ellen	—	Midwifery	—	20
	Yvonne	—	Nursing	ON(9)	3
	Fiona	—	Nursing	ON(8)	4
	Daisy	—	Midwifery	—	3
SH	Jessica	—	Midwifery	GN(1)	11
	Jenny	MM	Midwifery	GP(10)	6
	Maya	—	Nursing	GN(1)	9
	Anne	—	Midwifery	—	10

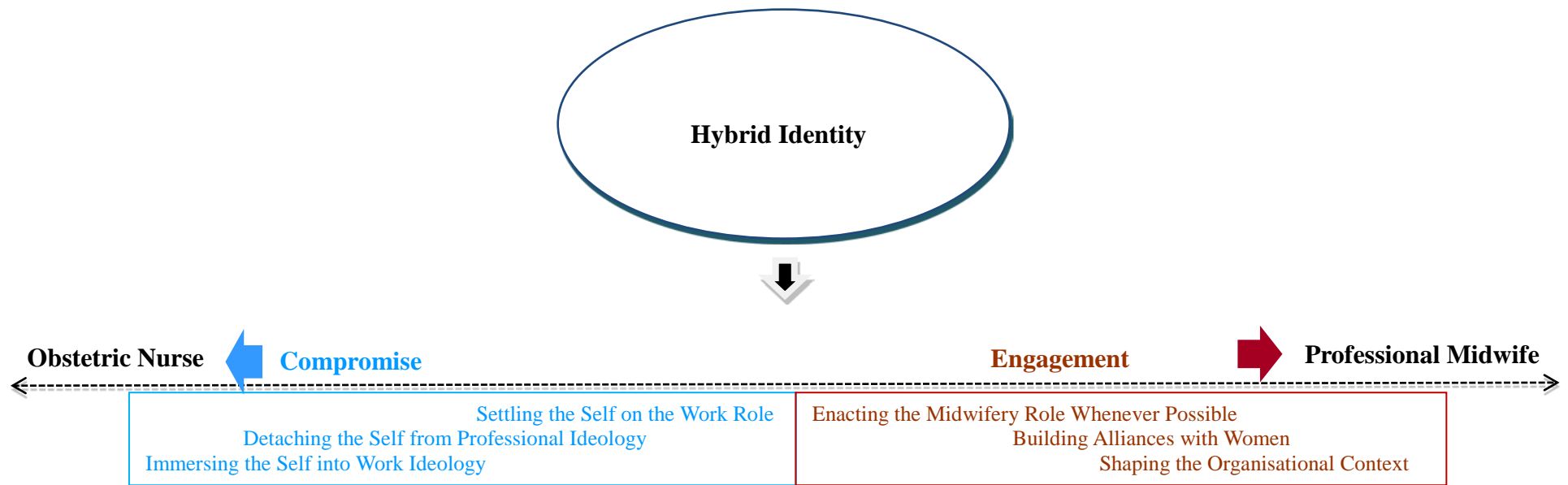
Notes: MM (Midwife with Managerial Position); GN (general nurse); ON (Obstetric nurse), GP (general practitioner in obstetrics and gynaecology).

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Figure

Figure1: 'Navigating the Self in Maternity Care'



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