A Master's Thesis:
Narrative Inquiry into Experiences of Professional Identity-Making in
Canadian Registered Midwives Who Have Also Worked as Maternal-Child Nurses

by

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Bachelor of Arts (Honours), University of British Columbia, 2005
Bachelor of Nursing Accelerated Track, University of Calgary, 2008
Bachelor of Midwifery, University of British Columbia, 2015

A Thesis Submitted in Partial Fulfillment of
the Requirements for the Degree of

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We acknowledge and respect the Lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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Abstract

Maternal-child nurses and midwives play essential roles in Canadian maternity care. They work within distinct yet overlapping professions, providing care from conception through the postpartum period in community and institutional settings. While they are university-educated through separate direct-entry programs and licensed via independent national processes, some Canadian midwifery education programs have an advanced placement option for nurse applicants. To my knowledge, no studies have inquired into the experiences of practitioners with both Canadian nursing and midwifery education and practice. I conducted a narrative inquiry into the experiences of Canadian perinatal practitioners with dual backgrounds in nursing and midwifery as they contend professional identity-making shaped by multiple temporal, social, and geographic contexts. I engaged with four participants in three to four 40-90-minute-long conversations over three to four months. Conversations were digitally recorded and transcribed verbatim to which I added field notes and personal reflections. I drew on the transcriptions and observations to create a personalized narrative account for each participant to represent their experiences and my related wonderings. I met with each participant twice more to negotiate the narrative account. With guidance from my supervisors, I analyzed the accounts for resonant threads. Two threads were prominent: professional identity is a fluid, continually negotiated experience, and identity-making is shaped by historical and social tensions. Rather than aiming to generalize, this inquiry draws on the depth and detail of personal stories unfolding in a relational space of inquiry to illuminate the richness of lived experiences. Findings invite new ways of understanding the identity-making of dual practitioners and have the potential to inform nursing and midwifery education and practice-based supports. The study raises new questions for

further research on contextual identity-making and the influences of power across perinatal education and care domains.

Keywords: midwife, nurse, Canadian, narrative inquiry, professional identity, dual registrant

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List of Abbreviations

Abbreviation	Unabbreviated
BC	British Columbia
BCCNM	British Columbia College of Nurses and Midwives
CAPWHN	Canadian Association of Perinatal and Women's Health Nurses
CNA	Canadian Nurses Association
CNM	Certified Nurse Midwife
ICM	International Confederation of Midwives
LDR	labour and delivery room/unit
MEP	midwifery education program
MRP	most responsible provider
NICU	neonatal intensive care unit
NRP	neonatal resuscitation program
OR	operating room
OB	obstetrician
PHB	planned home birth
PHN	public health nurse
RM	registered midwife
RN	registered nurse
UBC	University of British Columbia
UK	United Kingdom
WHO	World Health Organization

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Since entering healthcare, I have often reflected on shaping moments with my many mentors—stories I revisit long after. I suspect mentors rarely know the true extent of their impact. Among those who inspired and challenged me during my transition into midwifery, I gratefully recognize Maggie Ramsey, Luba Lyons Richardson, and Lorna McRae.

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My gratitude to my daughters, Eleanor and Madeleine: may your brilliant and curious minds and compassionate spirits bring you much joy, and some goodness to the world.

Dedication

To the nurses, the midwives, and all the mentors—

and to the families who entrust us with their care.

Language

I acknowledge the importance of inclusive language in research and healthcare as a part of upholding dignity for all people. This includes decoupling gender cisnormativity and pregnancy, and pregnancy and parenting. Not all individuals accessing perinatal care identify as women or mothers. Throughout this thesis, I commonly use gender-neutral terms such as *pregnant people*, *birthing individual,* or *caregiver* alongside traditional and gendered language such as *maternal*, *maternity*, and *women's health*. The variation in language throughout this text aims to convey respect for the diversity of human identities while maintaining alignment with the common terminology in this field.

Chapter 1: Narrative Beginnings

In 2005, while working as a community development intern in a Guatemalan women's organization, I met a Canadian nurse scholar during a pop-up health clinic in a rural community. Months prior, I had completed my first undergraduate degree in Latin American history and international relations yet had an insistent curiosity about healthcare. My paternal grandmother was a nurse and identified strongly as such despite having practiced only a few months before retiring for marriage and children. She had boarded and trained in a hospital-based nursing program in the 1940s in Saskatchewan. Subsequently, she maintained a nurse's good sense and ethic throughout her long life in her roles as homemaker, neighbour, wife, mother, then grandmother. I recall the saying: *Once a nurse, always a nurse.* My grandmother had provided my early window into nursing identity, then over the course of a single afternoon of conversation, Leigh[1] (the nurse scholar), revolutionized my perception. Modern nursing: a broad range of practice spaces and influence; research, education, and leadership; and endless opportunities to specialize. I wonder if my grandmother and Leigh could have negotiated a common nurse identity between them.

Beside the ragged table we'd set up for intake assessments I asked Leigh, *"Would you teach me to take a blood pressure?"* The line of men rerouted from their farm work to attend clinic was long and maybe I could help. When she said a firm no, that I needed to understand theory and so much more before I could perform that skill, I was dismayed, well beyond what seemed reasonable. I thought to myself: *Fine then. I'll become a nurse.* My family and friends knew me as someone who got dizzy at the sight of blood and needles, recoiled at the thought of

[1] All names in this thesis are pseudonyms, used to protect the privacy of both research participants and others referenced in personal narrative.

illness or demise. I did my best to reassure them and myself that I would not become a *real* nurse; I would become a public health nurse (PHN) where I would be safe from the gore and requisite grit that shaped my rough lines of inchoate nursing identity. I had admired the role of the PHN since I was 5 years old thanks to Margaret who came weekly to support my mom, who lives with hemiplegia, with my newborn sister. Broadly, I was drawn in by my positive assumptions about virtuous, tough-as-nails nurses whose combined knowledge, skill, and work ethic sustained an easily identifiable, coherent, *comfortable* global image of which I would be honoured to be a part. Within 23 months of this barred attempt to take my first blood pressure, I was a registered nurse (RN).

My passion for perinatal care ignited as quickly as the unexpected determination to become a nurse. A registered midwife (RM) guest lecturer conducted a two-hour maternity nursing class on physiologic birth, showed us a powerful video about coping methods for labour, and my career trajectory made a sharp turn. A few weeks later, I attained student nurse employment in a pilot project on a labour and delivery unit (LDR). They trained our group of five senior students to be labour support people with jurisdiction to perform a few nursing tasks such as measure urine output and perform patient hygiene under direct supervision of an RN. Upon graduation, for the next three years I worked full-time between two level two and level three LDRs in Calgary. There I walked straight into the human intensity and unpredictability that stalks the supposed *real* nurse that I cowered from at the outset.

My closest mentors, Nancy, Sue, and Ellen were senior nurses, often in charge, and included midwife within their informal introductions. After becoming RNs, they had each specialized by completing midwifery education in the United Kingdom (UK). They explained that there were no obstetrical nurses there; they were all midwives. All LDR nurses I have

worked with in Canada have also completed specialized education to competently fulfill their role; however, I perceived that these nurses who completed midwifery education abroad (in addition to their decades of experience) possessed an outstanding level of self-assuredness; knowledge of physiologic birth, subtle signs, and hands-on assessment; midwifery art and science; and rigorous yet sensitive routine that kept patients safe and satisfied. Nancy stressed, *Laura, when you take over for postpartum care, you must always, always put your hand on the uterus. It is the first thing you do.* We accepted a patient for break relief; Nancy placed her palm over the fundus and guarded with her other hand. Then, a breath later, the bed spilled over with blood and clots from the hemorrhage that was missed by our counterpart. *And that is why.*

After three years of LDR nursing, I desired greater expertise and a longer therapeutic relationship with the families that as a nurse I could only serve in twelve-hour intervals and then never saw again. I sought a way to expand as an RN, to extend my identity, and to practice throughout the full perinatal period from conception to the first weeks after birth. I wanted to be like my mentors who were nurses *and* midwives. I often saw them openly dispute physicians' assessments and care plans in ways that the Canadian educated LDR nurses rarely did. I had so many questions. I wondered, how do they experience their duties, skills, knowledge, philosophy, values, self-concept, and relationships in their daily work? How do they perceive themselves privately and in relationship with their clients and colleagues; are personal and public expressions of professional identity distinct? I perceived that my UK educated mentors held their nurse and midwife identities with ease and confidence. Yet, in the Canadian context, their formal role was exclusively as an RN. How did they experience and navigate this?

When I applied to the undergraduate midwifery education program (MEP) at the University of British Columbia (UBC) in 2009, I was ignorant of the distinct maternity care

history and political climate of midwifery in Canada. Unexpectedly, my plan to become a Canadian midwife was worthy of secrecy. After moving to Victoria, I entered the perinatal administration office with application in hand to seek employment as an LDR nurse at that hospital. I explained that I would really like to work there, that I was skilled, keen and experienced on two busy LDRs in Calgary. Then, replete with naïveté, I proudly said I moved here to become a midwife. I recall feeling that my declaration froze the room.

The administrator replied by advising me not to tell anyone my plans until absolutely necessary. I should just let them get to know me first. She leaned in, strained to soften, and shared that she was a midwife too, internationally trained, and would *never practice in Canada*. Quickly, I formed strong and cherished bonds with my new colleague nurses, enjoying their shared wisdom and community. Reluctantly, just before leaving Victoria for the mainland to start classes, I finally told a coworker. She was surprised, gave me an earful about inadequate training and renegade decision-making, but laid a bridge by asking, *Have you met Lesley? She was an RM here. Retired now. British-trained midwife. We liked her. She was a nurse*. Next, I was pressed about why I would want to leave nursing, a question I received countless times after. *But I'm not leaving nursing; I'm just becoming a midwife.* Over the next decade, I tried many forms of this reply, yet it never seemed to satisfy.

While I had thus far managed the climate of my nursing workplace through various strategies to sidestep oppositional politics, starting my midwifery education created an unremitting environment of navigating the external and internal conflicts between nursing and budding midwifery identities. During orientation week to the four-year UBC undergraduate MEP whose alumnae largely become practising Canadian registrants, I remember sitting in an introductory meeting with my new classmates and a program leader. The senior faculty member

introduced herself as having first been a perinatal RN. I was relieved to have found someone '*like me*' after meeting my new classmates who presented so differently than what I had anticipated. They were so *anti-* and *pro-*, and I was glad to find someone who understood institutional settings, until she said, *I never wanted to be political, but birth is political, and midwifery is political; whether you like it or not, you are now political*. And I thought, no, I'm not. I do not have to be. I'm a nurse and nurses are apolitical. Aren't they? My cursory impression of my classmates was that most were poised for politics. Was this truly central to Canadian midwifery? What would that mean for me?

I soon took full grasp of a fundamental tenant of Canadian midwifery that posed the biggest personal and professional challenge in transitioning from RN to RM in practice and in spirit: informed choice. The principle of informed choice holds Canadian RMs to respect the right of their clients to make autonomous informed choices about "all aspects of their care" (Canadian Midwifery Regulators Consortium, 2008, p. 2). It structures midwives' non-authoritarian approach as one that recognizes clients as capable primary decision makers within the context of their own lives. The informed choice standard is detailed by each Canadian provincial and territorial midwifery regulatory body (see, i.e., British Columbia College of Nurses and Midwives (BCCNM), 2021; College of Midwives of Ontario, 2020; Midwifery Regulatory Council of Nova Scotia, 2022; Ordre des Sages-Femmes du Québec, 2021; Saskatchewan College of Midwives Transitional Council July, 2024). It guides RMs to translate balanced evidence to discernible, relevant, unbiased information about what is known and unknown about treatment benefits, risks, and alternatives that families use in directing their own courses of action. To meet the informed choice standard of practice, RMs listen to clients and attempt to understand and appreciate what motivates clients' choices (Midwifery Regulatory

Council of Nova Scotia, 2022). Importantly, they support the outcomes of the informed choice process: clients' acceptance or refusal of the intervention. When the principle of informed choice is implemented as intended, it underpins all aspects of clinical care.

I experienced that upholding the standard of informed choice also influences a particular interdisciplinary dynamic between RMs and their nurse and physician colleagues whose education and professional socialization uphold the principle of informed *consent* (see i.e. (Canadian Medical Protective Association, 2024; Canadian Nurses Association, 2017; College of Physicians and Surgeons of British Columbia, 2023). Lacking the relational ethics commitments that shape informed choice, I observed that informed consent was often implemented in coercive ways that aligned care plans with medical norms established and embedded within a given unit. Midwifery's informed choice tenet offered me a valuable alternative. I had respect and appreciation for the underlying philosophy; yet, in practice I identify it as a great source of tension in my personal experience of negotiating dual RN and RM identities from the outset.

As a new graduate RM working with nurses, physicians, and administrators on the same LDR where I had recently worked for five years as an RN, I experienced repeated dilemmas while navigating patient choice that ran contrary to my colleagues' preferences. I recall transferring to hospital with an objectively high-risk patient who had made an informed choice to pursue a planned home birth (PHB) which I had professionally supported. Unsurprisingly with her history, a complication developed in labour at home that could not be adequately managed, and she agreed to seek specialist care. In these situations, I felt distressing conflict between my two professional identities that exist within broader systems of pressures and supports: the nurse in me supported patient choice but with more explicit professional boundaries and scope of practice protection than I was afforded under the woman-centred, individual- (rather than

institution-) oriented midwifery. Here, I was experiencing autonomy as an interdependent concept. I tensely held in tandem empathy for my angry, incredulous colleagues' who lamented they had to *clean up the mess* alongside a sense of indignation. I tried to nurture the part of me that silently resisted their negative judgements in favour of honest respect for my patient's choices with which I did not have to identify to accept. These tensions remain a part of me.

Throughout my MEP, I contended with Canadian midwifery politics and professional socialization that did not feel compatible with ways I had come to think. I found myself confronted by the impulse to centre my nurse identity as the key factor that differentiated me from what I was learning to do and be in midwifery. For example, while I was drawn to longitudinal care, at times I was uncomfortable situating myself in an intimate midwife-client relationship wherein I would become personally important to a family for many months or well beyond. In acute care, a nurse does not become individually vital because (s)he is replaceable after 8 or 12 hours and for each rest break. Here, the patient ought not and cannot depend on nurses as individuals, they need to depend on the *collective* nurse.

In contrast, the Canadian midwifery model of care is built on the principle of continuity of care viewed as a "continuous caring relationship and ongoing partnership with the midwife/midwives" (College of Midwives of Alberta, 2022, p. 6). To accomplish this, regional midwifery regulators specify ways in which midwives should organize their practice to ensure clients know their provider. For example, British Columbia (BC) permits no more than four RMs in a patient's care trajectory that are all known to the patient (BCCNM, 2024). In Alberta and Newfoundland/Labrador regulation, every effort should be made that the midwife attending birth is known to the client (College of Midwives of Alberta, 2022; College of Midwives of Newfoundland and Labrador, 2019). My ongoing struggle to deeply integrate Canadian

midwifery tenants such as informed choice and continuity of care into my midwifery practice and midwife ego felt like personal moral failures and professional burdens. Was this ethical dissonance or cowardice? I wonder what sorts of educational, social, or practical supports for these topics might have helped me to thrive as an RM after starting as a Canadian RN.

The fact that I lacked historical context for Canadian nursing and midwifery, and insight into their unique professional socialization challenged me in navigating relationships with preceptors and faculty. I was not strong at adapting to my new practice culture partly because the nurse in me retained a sense of responsibility for maintaining trusting relationships with the acute care community of which I still felt deeply a part. Regrettably, at times I instigated conflict during clinical placements in hospitals I had never previously visited when I would more commonly side with the LDR nurse over my RM preceptor. This occurred at moments where seemingly banal institutional standards were in question, and when I detected something that concerned me through my nursing vantage that my preceptor favoured to normalize.

I tended to feel an easy affiliation with nurses and a defensive apprehension with my preceptors who most often met my adversarial attitude (which I look back on with shame) with force rather than curiosity or compassion. Several preceptors (each also educated as RNs who were early midwifery registrants upon regulation in BC) took their own approach to '*de-nursify*' me in a well-meaning attempt to make me a midwife. This curious process resulted in midwifery knocking me somewhat out of nursing, while deeply embedded nursing preventing me from becoming a *real* midwife. Who had I become? Both or neither? How has this been for others? I seek to understand the experiences of holding dual professional identity from other practitioners who, like me, were educated as RNs and RMs in Canadian institutions and who have practiced in Canadian perinatal settings.

Registering as a midwife then returning to the same community where I had nursed for four years prior with the same colleagues forced me to contend nursing and midwifery identity daily. I grapple with questions over what we are and what we do. Sometimes colleagues and patients offer me new pieces of Canadian nurse and midwife to spin around, examine, and try to fit into my own puzzle. The other day while working a midwifery shift in an outpatient clinic in the hospital, I passed a colleague nurse of 15 years in the hallway. I said, *It's busy in here today, Jane!* She replied, *That's the nurse in you, Laura*. It is? These examples of common interactions make me curious about how my colleagues perceive what I know and do, what I support and oppose, and the person I am when I am acting in one role versus the other. Regularly colleagues introduce me, *This is Laura. She used to be a nurse.* I did not used to be a nurse; I *am* a nurse! I am like my grandmother; she was a nurse until the end. I saw it in her daily command: how she ordered her house; how meticulously she made us wash our hands; how she concerned herself with my restful sleep; how she dressed a cut. How does a person *un*-become?

Six years ago, I experienced an unraveling of my midwife self when I suddenly left practice. I had been back to work for only a couple of months following maternity leave with my second child. That postpartum year had been unfamiliarly difficult. My spouse and I blindly hoped that my return to midwifery would be the lifeline to pull me out of those dark and disorienting places and back into myself. However, the 24/7 grueling barrage and a series of heart wrenching cases sent my nervous system to an unrecognizable state. I left on medical leave. I inactivated my licence and relinquished my hospital privileges which I had felt so accomplished to acquire. I was certain I would never work in maternity care again, the only setting I had ever served, the only healthcare community I had ever been a part. I could no longer legally refer to myself cleanly as a midwife; now it was "non-practising midwife" (BCCNM,

2004) which I felt underscored the erasure rather than retained the core identity. While I had been able to retain my self-perception as nurse despite not practicing in nursing roles for six years, I perceive that without performing the work of a midwife, I truly was not one anymore. Maybe a person can *un-become* after all.

At this time, I burned with resentment toward midwifery and the sacrifices my family and I had made to have this career. I dwelled on cruel memories like the labour I had to attend for lack of call coverage, directly after learning the first trimester I endured was a twin pregnancy that had stopped. I evoked how it felt to shuffle the hospital halls bleeding and sore from my dilatation and curettage the day before; I was back to care for the next client's labour. Being a midwife is everyone else first, always. I recalled my panic over the chance the pager might ring the night I had to spend alone with my toddler; my childcare had left urgently to be with my aunt who was unexpectedly on life support. How dare panic has been allowed in the space grief was due. Nursing would not have treated me like this. But midwives are martyrs.

I have rewritten sections of my narrative beginnings several times, a testament to the many stories–overlapping, changing, contradictory–we tell ourselves and others. Finally, I try to bring a sense of present-day reflections on my professional identity as a dual registered RN and RM, yet a new experience, mood, interaction adds a new shape. I note Clandinin and Caine's (2013) words, "people are always becoming" (p. 176) which resonates deeply. Despite my certainty to the contrary, I reengaged roles in maternity care. Two years ago, I returned to a nursing role in caring for childbirth. Curiously, I have found that as an RN caring for labouring families within that scope and role, I feel that I am now my best midwife. I am *with woman* (the root concept of the term midwife) in authentic yet self-preserving ways. And a year ago I re-registered as a practising midwife though in a new model in which I provide antenatal care in

shifts. Adjustments in BC midwifery regulation and remuneration models during my four years of leave cracked open access to some different ways of practice. For the first time, I am both a dual registrant and simultaneously practice formally in each role. From here, can I make sense of an integrated Canadian RN and RM identity?

After all this, I have more education, perspective, assertiveness, and advanced skills. I am a bit closer to what I saw in my nurse-midwife mentors. It is not the professional autonomy that I need to be my best midwife and to feel more often that I may have arrived at a more coherent sense of my professional self. I do not find I need to be the first to place my hand on the baby at birth to confirm my midwife identity; I do not locate myself in *the catch*. In fact, I recognize now how my resentment for the punishing nature of the on-call lifestyle bound to the continuity of care principle felt like barriers to taking hold of *midwife* the way I believed I was supposed to. These personal reflections on my dual registrant experiences raise some clues and many questions around professional identity-making in this setting that I am curious to explore with others.

Turning to my Research Puzzle

My research puzzle stems from a curiosity about the experiences of Canadian maternal-child nurses and Canadian midwives. What are the experiences of people who have been educated and practiced in both professions? What shapes their professionalization, and how do their respective histories shape their self-perceptions? I seek to develop a nuanced understanding of professional identity that could inform and support advanced education programs in both fields. How might administrators and educators better support students transitioning from one profession to the other? What needs might this group have that are unnoticed or unmet by existing curriculum and support systems? I also wonder what tensions and interprofessional

synergies dual-qualified practitioners experience, and how these influence their workplace satisfaction and career longevity. More broadly, how do individuals who hold both nursing and midwifery designations make sense of their professional identities?

Chapter 2: Literature Review

Exploring the evolution of Canadian nursing and midwifery professions helps to situate contemporary practitioners' narratives within historical contexts. Beginning with the history of childbirth in Canada, I will progress to explore the history of Canadian nursing including its professionalization and development of subspecialities. In addition to focussing on the origins of maternal-child nursing practice, I will discuss the formation of certified practice areas and their professional associations. I will explore the history of midwifery, first from a global perspective then in the Canadian context. I will review literature on professional identity-making, including narrative explorations of nurses and midwives, revealing the absence of attention to Canadian dual practitioners' experiences. This literature review provides context to my research puzzle and highlights knowledge gaps.

History of Childbirth in Canada

Within the Canadian context, Indigenous peoples have upheld extensive knowledge and practices in relation to childbearing. They fulfilled vital community roles as attendants of birth that was regarded as a "cultural and spiritual process rather than an individual act or medical event" (Benoit et al., 2007, p. 508). European contact in the 1600s and subsequent imposition of colonial structures dramatically transformed how, where, and by whom care was provided. Beginning in the 1700s, immigrant settler groups started to develop maternity care systems that blended familiar customs from their homelands with Indigenous practices they observed (Benoit et al., 2007; Mason, 1988). Lay midwives with no formal education were often older women elected in settler communities to serve as childbirth attendants.

Within a century, regulatory changes, including the first medical acts, began to shift authority over childbirth to academically trained physicians and barred unlicensed practice

(Biggs, 2024). Women were prohibited from formal Canadian medical education until the 1880s (Benoit et al., 2007). This new paradigm disavowed alternate sources of knowledge, such as experiential, tacit, and oral traditions, and positioned literacy and academic medical knowledge as the only legitimate forms of expertise (Biggs, 2024). The combination of these factors instigated the decline of traditional midwifery and resulted in both male and medical monopolies over childbirth (Biggs, 2024). Yet, prohibitive physician service fees and limited or no access to "medical men" in rural and remote areas kept some midwives active into the early 20th century, with notable regional differences (Biggs, 2024, p. 23). The growth of medical dominance, regulatory forces, and physicians' perception of economic competition with the remaining midwives, pushed midwifery further to the margins.

Risk discourse accompanied the medicalization of childbirth (MacKenzie Bryers & Van Teijlingen, 2010). Over the early 20th century, the perinatal period became widely interpreted as dangerous. Biomedically trained professionals using increasingly complex technologies to manage this life stage became regarded as the solution to real and perceived perinatal threats. Cartwright and Thomas (2001) explain, "as childbirth moved from a domestic to a medical event, obstetrical dangers became institutionalized within a growing body of medical knowledge" (p. 218). A combination of social, political, and economic forces—particularly those steered by the Canadian medical profession—moved childbirth care from home to hospital. Surgical delivery by cesarean section began in the late 19th century (Scamell & Alaszewski, 2012), rising to 6% of births in the 1960s, and 12-15% in the 1980s (Baskett, 2019). Teams comprised of physicians and obstetrical nurses led the provision of hospital-based birth care accessible first among the urban middle class (Benoit et al., 2007). The structure spread progressively, albeit at uneven rates, across Canadian society.

After the Medical Care Act of 1968 passed, the federal government implemented universal health insurance, granting free access to physicians' care and hospital services. This resulted in reinforcing the medical monopoly on maternity care and "did nothing to alleviate the pre-existing disparity in healthcare availability between rural and urban areas" (Benoit et al., 2007, p. 516). Local perinatal care services were inadequate or absent in many rural and remote regions. In Indigenous communities, this was in large part a direct result of colonial destruction of community-based Indigenous midwives (National Council of Aboriginal Midwives, 2020). Federal policies followed, forcing relocation of "all rural or remote reserve-living pregnant women between 36 and 38 weeks' gestational age to use labour and birthing services in urban centres" (Cidro et al., 2020, p. 175). Despite advocacy to end the blanket policy and the gradual rebuilding of Indigenous midwives[2] to safeguard birth in community, forced birth evacuation continues today with profound and extensive negative impacts (National Council of Aboriginal Midwives, 2020; Silver et al., 2022). Non-Indigenous rural and remote inhabitants also face relocation for lack of access (Grzybowski & Kornelsen, 2004). For example, this practice became increasingly common in BC with the decline of rural maternity care infrastructure in the 1990s (Kornelsen, 2003).

Operating in the context of a national maternity care crisis (Kornelsen, 2003; Price et al., 2005), perinatal services for the more than 389,000 annual births occurring in Canada (Moola, 2018) rely on coordinated, skilled care from conception to at least six weeks postpartum. Today primary maternity care providers are mainly comprised of general obstetricians (OBs), family

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[2] There are significant distinctions between the roles and presentations of Indigenous and settler midwifery in Canada (Benoit et al., 2006). This includes that Indigenous midwives and Indigenous midwifery care are unique in their core competencies, position, and roles in their communities as "keeper of ceremonies" (The National Council of Indigenous Midwives, 2019). The histories and experiences of Indigenous midwives will not be well represented in this thesis as participants were recruited from the mainstream population.

physicians with maternity training, and registered midwives (Kornelsen, 2022). There are a few consultant perinatologists specializing in maternal-fetal medicine and obstetric internists to manage maternal medical complexities in some major urban referral settings (Magee et al., 2016). In the inpatient setting, nurses represent the most numerous profession within the multidisciplinary team with over 14,000 Canadian perinatal RNs (CNA, 2011). Perinatal care providers and nurse staffing levels have been insufficient in many communities for over three decades (Moola, 2018; Wagner, 2023); meanwhile, the national perinatal care needs are increasingly complex (PHAC, 2022; Statistics Canada, 2023). The inpatient course typically requires the most elaborate organization of human resources to coordinate and optimize knowledge and skill within this institutionalized system of care (Wagner, 2023).

History of Canadian Nursing

The history of nursing in Canada reflects a journey from community-based Indigenous and settler midwives and lay healers (Bates et al., 2005) to a diversely skilled, regulated profession operating in many practice settings. Beginning in the 17th century, French Catholic nuns established some of Canada's first hospitals, "religious space[s]in terms of both [their] origins and [their] purpose" (Violette, 2005, p. 58). These were tended by nursing sisters fulfilling Christian principles of charity, mercy, and salvation. Formal nursing education began in the late 19th century with hospital-based training schools emerging across the country. The first such program opened in 1874 based on the Florence Nightingale training model: the "Nightingale system" (McPherson, 2005, p. 76). By the 1920s, there were over 200 programs with student nurses staffing the wards (McPherson, 2005). Graduates largely exited for public health or private duty work (McPherson, 2005).

The Canadian Nurses Association (CNA) was founded in 1908 from nursing groups across the country to structure and standardize professional nursing training and practice (Almost, 2021). In 1910, Nova Scotia was the first province to pass registered nursing legislation allowing voluntary registration; by 1967, all provinces had some form of registered nursing legislation, with the territories following later (Almost, 2021). By the mid-20th century, nurses' publicly perceived essential work expanded to a wider range of specialized hospital and community-based roles (Mansell, 2004). These included multiple specialization (including certified practice), advanced practice areas[3], and involvement in policy, administration, education, and academia (Almost, 2021). In Canada, entry-level nursing education typically requires graduating with a bachelor's degree in nursing from an accredited program and passing the national licensing exam (i.e., NCLEX-RN), except in Quebec where a diploma and a provincial exam are required. In 2019, there were 439,975 regulated nurses from four designations (i.e., licensed/registered practical nurses, nurse practitioners, registered nurses, and registered psychiatric nurses) with active licences in Canada (Almost, 2021).

History of Canadian Maternal-Child Nursing

With increasing role formalization over the past century, Canadian nurses work in numerous practice settings tending to the needs of pregnant, birthing, and postpartum individuals, and their babies. Often the only health professional outside of urban communities, public health nurses provided early maternal-child health nursing with responsibilities that included prenatal education (Marcellus, 2019). In an early 20th century publication by the

[3] Almost (2021) explains while that most RNs engage in hospital-based work, alternative practice settings are varied and include, "residential care facilities, community health centres, independent practices (self-employed), faith communities, industry, mental health facilities, clinics, schools, colleges and universities, clients' homes, the streets, correctional facilities, research institutes, professional nursing and health-care organizations and government agencies and departments" (p. 13).

Victorian Order of Nurses for Canada, Prichard (1923) conveys that nurses organized within a post-war “era of conservation of life” (p. 322) with an impetus to protect and nurture mothers and prevent perinatal loss. Prichard’s impassioned call to action to oversee maternal-infant needs at all stages, summons nurses to take seriously their role in maternity care as a matter of “national importance” (p. 324). This author stresses nurses’ role in the effort to “restore the health and vigor of Motherhood of our nation” (p. 324). She advises nurses to develop a listening and supportive relationship with expectant and new mothers. Further, she implores them to assume a leading role in educating women on “the importance of medical and nursing care; to give the babe the right not only to be born, but to be born alive” (Prichard, 1923, p. 322). With hospital as the only formally accepted birth setting by this time, obstetrical nurses were born of Canadian physicians’ desire for hospital-based assistance and nursing lobbies themselves (Benoit & Carroll, 2005). Medicare’s establishment in the 1960s combined with nursing’s increasing professional sophistication created the environment for formally structuring maternal-child nursing throughout the maternity care system.

Marcellus’ (2019) analysis of maternal-infant health and nursing issue trends as written in The *Canadian Nurse* journal between 1905 and 2015 reveals the evolution of perinatal nursing practice in response to scientific advancements and changing sociocultural values. The author illustrates the ways in which nurses and their practice are positioned within the conflicting paradigms related to science and technology, natural childbirth, women’s autonomy, and risk management. Received by every Canadian RN as part of professional membership, *Canadian Nurse* serves professional networking and education purposes (Marcellus, 2019). During her review of 110 years’ worth of issues, Marcellus identified 668 publications that focused on maternal-infant health and nursing practice. Over the first 40 years, articles resembling textbook

teachings (see i.e., Breslin, 1907) gave detailed, practical information on expected nursing care, "including preparation for birth with procedures such as enemas, shaving, positioning, and draping" (Marcellus, 2019, p. 59). Influenced by Nightingale's military-style organization, aseptic science that emerged in the mid-19th century, and new medical technologies, nurses adopted regimented practices. These included detailed preparations to maintain sterility during childbirth (Marcellus, 2019). Marcellus' review reveals the evolution of maternity nurses' roles from routine tasks to more specialized and technology-driven responsibilities which had the effect of enhancing their perceived value in the health system.

Maternity Nurses, Technology, and Risk Discourse.

Antenatal, intrapartum, postpartum, and neonatal intensive care (NICU) nurses work almost exclusively in protocol-laden hospitals with increasingly specialized and technical responsibilities. There they contend the use of pervasive technologies which inexplicitly make many perceived dangers "more visible or measurable" (Cartwright & Thomas, 2001, p. 219). Publications aimed at perinatal nurses guide them with ways to lessen the likelihood of involvement in a negative-outcome situation. Phillips (1999) underscores competence, communication, and charting as essential nurse risk management strategies. Yet focused exploration of how these nurses live and make sense of internal and external circumstances is scarce in literature. In a master's thesis, Reger (2017) researches LDR nurses' experiences of their own pregnancy and birth, including in the presence of poor outcomes. The author analyzes LDR nurse participants' three-fold intersecting identities as person, nurse, and mother. MacKinnon (2010) attempts to understand the experiences of BC rural nurses providing maternity care in their local hospital. The author identified nurses' difficulties in learning and providing safe, supportive maternity care (MacKinnon, 2010). The ways in which Canadian

nurses working in areas of maternal-infant health experience legal, political, environmental, social, and professional forces is understudied.

According to a review of calls to the Canadian Nurses Protective Society between 1994 and 1997, Phillips (1999) reveals maternity "as the highest risk area in nursing where a negative-outcome incident can occur" (p. 45). Further, the author identified labour and delivery as the highest risk area for litigation. Kelly et al. (2023) examine the impact of biomedical and medical-legal risk discourses on how obstetrical nurses' organize their responsibilities for fetal surveillance work. Maternity nurses are socialized into this high-risk practice domain where malpractice and negligence lawsuits are relatively common. It stands to reason that this would have implications for how nurses experience themselves and their role. Indeed, I recall an early LDR nurse mentor impressing upon me, *Here it is not a question of if you will be tied to a court case; it is a matter of when*. This warning shaped my care and sense of professional responsibility, yet I have not been able to locate Canadian maternal-child literature exploring nurses' experiences more broadly.

Professionalization of Maternal-Child Nursing.

Today, there are several areas of nursing with significant maternal-child components: obstetrics, neonatal intensive care, postpartum, public health, pediatrics—all which have professionalized within Canada. Most nurses working in these areas are RNs. The Canadian Nurses Association Certification Program currently recognizes 22 nursing specialty areas for national certification (Almost, 2021): neonatal; perinatal; pediatric; and community health nursing which includes public health (Canadian Nurses Association, 2025). Professionalization is further supported by official specialty networks (Canadian Nurses Association, 2024) in the form of professional nursing associations such as the Canadian Association of Perinatal and Women's

Health Nurses (CAPWHN) (Canadian Association of Perinatal and Women's Health Nurses, n.d.). In addition to leadership and advocacy, CAPWHN publishes position statements and standards, including a guiding document, *Perinatal Nursing Standards in Canada* (2018), which supports these nurses' excellence (Canadian Association of Perinatal and Women's Health Nurses, 2018). The Canadian Association of Neonatal Nurses (Canadian Association of Neonatal Nurses, 2020) and the Canadian Association of Paediatric Nurses (Canadian Association of Paediatric Nurses, n.d.) serve similar roles for their respective clinical specialties. They connect members, advocate for nurses' needs and relevant health policy, support specialty professional development through conferences and research, and champion professional standards.

Midwifery from a Global Perspective

Midwifery is commonly considered the world's oldest profession, and by some as "the first holistic profession in the world" (Barnawi et al., 2013, p. 114). The International Confederation of Midwives (ICM) (2024) provides the contemporary global definition of midwife wherein,

> A midwife is a person who has successfully completed a midwifery education programme based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education, recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife,' and who demonstrates competency in the scope of practice of the midwife. (pp. 1–2)

They go on to describe the midwife's scope of practice:

> The midwife is recognised as a responsible and accountable professional, who works in partnership with women to give the necessary support, care and advice during pregnancy,

> labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. (pp. 1–2)

It is important to note that there are significant regional differences in midwifery models of care, scope and setting of practice, status, and integration into the established healthcare system. Often midwifery is an additional qualification for RNs, though direct-entry midwifery is also common in many areas of the world (Benoit et al., 2001; Zhou & Lu, 2018) as is the case in Canada (Butler et al., 2016). The World Health Organization (WHO) (2024) advocates for midwives to be educated to international standards and fully integrated as licensed and regulated caregivers within interprofessional teams. By accomplishing this and including family planning in their service delivery, the WHO (2024) asserts that more than 80% of all maternal and perinatal loss could be averted. Around the world, midwifery is challenged to balance traditional knowledge and a philosophy that largely privileges childbearing as a normal physiologic process alongside modern medical standards for maternal-child care.

History of Midwifery in the Canadian Context

Starting in the late 1960s, a growing number of Canadians began to challenge routine obstetric practices within the ubiquitous biomedical approach to childbirth (Benoit et al., 2007). In addition, Relyea (1992) highlights women's determination to "demedicalise normal birth and return it to the domain of women" (p. 159). Canadians organized into advocacy groups comprised of consumers and people interested in birth work (including lay and internationally trained midwives) to lobby for family-centred childbirth alternatives to the institutional hierarchy

of hospitals (Kaufman, 1998). Benoit et al. (2007) explains that the Home Birth Movement underpinning these efforts first started in countercultural groups before taking hold more broadly. Allemang (2010) points out that support came primarily from the white middle class. By the mid-1980s, there were women's groups in most Canadian cities advocating to establish midwives as a care option.

In Sangster and Bayly's (2016) Saskatchewan-based study, "Anarchists, Naturalists, Hippies, and Artists: Beliefs About Midwifery Care and Those Who Choose It" demonstrate that the legacy of these roots persists today in the imagination of many consumers, profoundly influencing their image of RMs and their care. Though historically more nuanced than popularly imagined, Allemang (2010) examines the "midwife-witch on trial" (p. 10) narrative prominent in North America during early calls for reviving midwifery. While assessing this construct from a historical perspective, the author also cautions the need for attention to its enduring impact on Canadian RMs identities and functions within the interdisciplinary perinatal care and broader communities.

The eventual introduction of the first regulated Canadian midwives in 1993 was subject to an enormous degree of controversy (Burtch, 1994). Midwifery Task Forces (such as the one in Ontario that published an executive summary, over 400 pages in length (Task Force on the Implementation of Midwifery, 1987) evaluated and proposed options for education/training, scope, model of care, remuneration, and level of integration. Practicing care providers participated in studies and committees weighing in on if and how midwifery services might be implemented in contemporary society. This includes Blais et al.'s (1994b) study using data from a systematic random survey in Quebec completed in 1991 by 597 physicians, 723 nurses, and 92 midwives on the form of midwifery practice they preferred to see in their province. Of note, 77-

80% of physicians, and 90% of nurse respondents indicated that midwives should first be trained as nurses (Blais et al., 1994b).

Persistent tensions stemmed in part from ideological differences toward childbirth and distrust that homebirth could be offered to modern safety standards. Debate over homebirth safety, protocols, and feasibility spanned two pre-registration decades through the start of the 21st century (Dixon, 1987; Fawcett et al., 2002; Goodwin, 1997; McLachlan & Forster, 2009). Midwifery's attempt to address rampant homebirth-focused concerns resulted in a swath of Canada-based studies only possible once legislation to practice was in place. Once RMs were regulated in BC in 1998, The Home Birth Demonstration Project was incorporated into the BC Health Professions Act, and active for the first two years of regulated practice in the province. It upheld a mandate to evaluate home birth provision by RMs including effective coordination with the broader support system such as emergency services for home to hospital transfers (Kornelsen & Carty, 2004). As years into registration accumulated, data became available to examine the contentious homebirth issue from several angles including maternal-neonatal safety (Darling et al., 2024; Hutton, 2016; Hutton et al., 2009; Janssen et al., 2015; Vedam et al., 2012, 2014); distance from hospital (Darling et al., 2019); and policies and procedures (Janssen et al., 2003).

Education and Training of Canada's First Modern Midwives

During a 1981 BC maternity care conference, "Midwifery is a…Labour of Love," the then lay midwife Luba Lyons describes the ways in which some of the first contemporary Canadian midwives organized, trained, and practiced:

> And so, I became a homebirth advocate. Other people in my area, not just because of my feelings, but because it was a growing movement, began to want their own children to be born at home. And people came to me and they said, "Luba, we're going to have our baby

at home alone, but we are wondering since you've had a baby at home if you would come, just to be there because you know more than we do, even by having been at one. And so I said, "Sure, great, wonderful, I'd love to come to another birth." And that's how it began.

My first ten births I attended in that manner, just simply because I was the only person in the neighbourhood that had been to a birth. And so people wanted me to come. The first ten births, as I remember, were totally straight forward and wonderful, and then I began to feel, I don't know enough, what if something goes wrong? What if I don't know what I'm doing? What if somebody gets into trouble? What am I going to do. So my next thought was I had better get educated. But there was no place to be educated. So I went back to my midwife, who had 150 births under her belt and I asked her, "Could you teach me?" and she said, "Well, the first thing to do is buy a Myles Textbook for Midwives and I'll lend you William's Obstetrics. So I took them home […]. (Lyons, 1981, p. 3)

Benoit et al. (2007) explain, "while they augmented their experience with weekend workshops, observation, and labour coaching in hospitals and occasionally short courses taken outside the country, the style of practice of most of these midwives was very informal" (p. 519). This includes boundaries (many clients were or became friends), and payment which was flexible. Women who entered lay midwifery practice in Canada often had had their own "traumatic and alienating birth experiences" (Benoit et al., 2007, p. 520) and sought to create a different model.

Relyea (1992) shares important history of another avenue through which midwives gained education. In the mid-1980s, four Canadian hospitals, including Grace Hospital in BC and Foothills Hospital in Alberta, began in-service midwifery education for selected obstetric nurses. This allowed these nurses to gain the knowledge and skills to fulfill "extended roles, providing

midwifery care to women and families through the antepartum and intrapartum period" (Relyea, 1992, p. 167). Additionally, the University of Alberta Faculty of Nursing began a midwifery certificate programme in 1987 in conjunction with their Master of Nursing degree. Relyea (1992) explains that the program goal was to "prepare midwives who will offer leadership to the development of the profession" (p. 167). Early leaders and registrants of Canadian midwifery were a blend of self-educated or community apprenticeship model midwives with internationally qualified midwives, and Canadian RNs (Kaufman, 1998).

The Organization of Contemporary Canadian Midwifery

Today, Canadian midwives are autonomous, primary healthcare providers delivering comprehensive care from conception through at least six weeks after birth (Canadian Association of Midwives, 2023c). They mainly work out of community clinics, as well as provide care in clients' homes and in the hospitals where they can gain admitting privileges. Canadian RMs conduct complete care throughout pregnancy which includes ordering and interpreting investigations such as bloodwork and medical imaging. They have jurisdiction to prescribe and administer medications relevant to their care. Canadian midwifery is provincially/territorially regulated (Canadian Midwifery Regulators Consortium, 2008). Though two provincial colleges (i.e., BCCNM and College of Nurses and Midwives of Prince Edward Island) oversee regulation of both nursing and midwifery professions, they do so with strict separation between the two. In other regions, midwifery and nursing are managed by separate colleges. Scope of practice restrictions and standards of care frameworks are maintained by each regional regulator.

An overarching set of Canadian Competencies for Midwives outlines entry-level midwife knowledge, skills, and competencies (Canadian Midwifery Regulators Consortium, 2008). They are aligned with regulatory bodies' competency statements though do not supersede them. The

model of midwifery practice, however, is national. The profession is underpinned by a regard for childbearing as a normal life process best supported by promoting wellness through tending to social, emotional, and cultural elements in addition to physical aspects (Canadian Midwifery Regulators Consortium, 2008). The tenants of informed choice and choice of birth setting (e.g. home, birth centre, hospital) reflect Canadian midwifery's dedication to promoting clients' rights to autonomous decision making at all stages in the perinatal care trajectory. These are supported by the requirement to provide up-to-date, evidence-based practice. The Continuity of Care tenant encapsulates Canadian midwifery's commitment to developing a trusting longitudinal relationship with clients. Care is individualized by a midwife who is known to the client and available on-call throughout the care relationship. This care relationship may transpire between RMs who work independently (i.e. "solo") or in small, consistent groups.

Establishing regulated midwifery across all provinces and territories took two decades, with Ontario being the first to regulate in 1994. Bourgeault's 2006 book *Push!: The struggle for midwifery in Ontario* details this complex integration history. Thus ended Canada's long-held status as the "only industrialised nation which did not have legislation which supported midwifery practice" (Relyea, 1992, p. 159). Several provinces followed, culminating in Prince Edward Island achieving regulation in 2022 (Canadian Association of Midwives, 2023a). Today's Canadian midwives are educated through a three to four year baccalaureate program at one of six recognized midwifery programs (Canadian Association of Midwives, 2023b). To qualify for registered practice, graduates must pass the Canadian Midwifery Registration Exam. Successfully completing this licensing exam renders graduates eligible to apply to any regional regulator to practice midwifery. Some Canadian midwifery programs such as UBC have a bridging program for internationally educated midwives (University of British Columbia, n.d.-a),

and/or an advanced entry stream for people with health professions experience such as nurses (see, i.e., Toronto Metropolitan University, 2024; University of British Columbia, n.d.).

Midwifery across Canada has experienced many gains including more coordinated integration into the healthcare system, improvements to remuneration, and somewhat increased flexibility in practice model and scope. For example, the BCCNM now has a mechanism for midwives to apply to conduct care under a carefully monitored alternate practice arrangement (BCCNM, 2024a). Such arrangements permit midwives to offer care outside the standard model; for example, an exemption from standards that require practice in a team of no more than four primary care providers. They also consider requests for exemption to the standard requiring comprehensive care prenatally through postpartum. This alternate practice arrangement permits midwives to work in one or two stages rather than requiring them to attend the full perinatal period; it creates the possibility for no on-call work when the intrapartum period is exempt.

Challenges for Canadian RMs include burnout and retention difficulties. Cameron (2011) identified that between 1994 and 2008, 108 out of 518 Ontario midwives left the profession, an attrition rate of 21% (p. 23). Through in-depth interviews, this author explored reasons for attrition that included a disparity between RM's ideal and lived practice experiences. In their pan-Canadian midwifery study, Neiterman et al. (2021) cite data from 2015 indicating "that the percentage of inactive midwives ranged from 8.6% in Alberta to 13.7% in Ontario" (p. 29). Newer studies by Cates et al. (2024), Thiessen et al., (2024), and Darling et al. (2023) elaborate on factors that negatively impact Ontario midwives' mental health such as the culture of the profession and call model. For example, participants in Cates et al.'s (2024) study revealed "uncertainty and unpredictability" (p. 4), along with "vicarious trauma and emotional labour" (p. 4) as subthemes that threatened midwives' emotional and psychological wellbeing. While they

do not provide an updated attrition rate, Stoll and Galagher (2019) illuminate negative impacts of working on call, and midwives' worries about mental and physical health in connection to intention to leave practice. Their study indicated that 34.7% of Western Canadian RM respondents had seriously considered leaving the profession (Stoll & Gallagher, 2019). Comparing the BC and Alberta midwifery populations, Butska and Stoll (2020) identified insufficient remuneration per course of care as a primary factor in BC midwives' burnout.

Interprofessional acrimony, particularly between RNs and RMs also negatively affects midwives. This was particularly evident in the early years of regulation, as midwives providing care in hospitals faced challenges in gaining social acceptance within the medical establishment (Kornelsen et al., 2003; Kornelsen & Carty, 2004; Macdonald et al., 2015; Neiterman et al., 2024). Zimmer's (2006) doctoral dissertation explored perinatal nurses' and midwives' experiences of working together in inpatient birthing settings. The BC-based hermeneutic study shows that collaboration between nurses and midwives as often strained by mistrust, conflicting views on childbirth and risk, and a sense of otherness, which can undermine collegiality and "disrupt the moral space of birth" (Zimmer, 2006, p. iv). Later, MacDonald's 2019 doctoral dissertation through a feminist poststructural lens examines RN and RM experiences of collaboration in Nova Scotia in both home and hospital birth settings. This research offers positive and hopeful examples that may point to improved relations over time and/or regional differences, despite systemic challenges facing both professions (MacDonald, 2019; Macdonald & Etowa, 2021). As Kauffman (1998) states in her paper about Ontario midwifery history, "the tension between groups of health professionals also is part of the history of childbirth care" (p. 977).

Theory of Professional Identity Development

Several disciplines including sociology, psychology, and education are credited with contributions to theory of professional identity development from the start of the 20th century. For example, Erik Erikson influenced later theories on professional identity through his understanding of psychosocial development (e.g. identity vs role confusion during adolescence). This laid the foundation for individual-oriented (i.e., ego) theoretical approaches (Cornett et al., 2023). From this perspective, professional identity encompasses, "an actualisation of one's morals, values and beliefs giving meaning to oneself and one's professional life" (Cornett et al., 2023, p. 590). Sociological theories also contributed to conceptualising professional identity, specifically by tending to how professionals navigate institutional settings and social structures to develop their sense of self. From a social perspective, identity develops in social and cultural relationships. Collective professional identity reflects the social aspects of identity in relation to a group and make way for professionalization. Proponents of a third approach, poststructural, assert that discourse (i.e. "language in use" (Zembylas, 2003, p.591)) is responsible for the social construction of the self. Here the self is embedded within sociocultural, ideological, political contexts and is shaped by power relations (Zembylas, 2003). Rather than a fixed entity, the poststructural view regards identity as a fundamentally dynamic process, neither progressing nor regressing yet *becoming* (Zembylas, 2003).

Identity-Making in Nursing and Midwifery

The wealth of academic interest in professional identity-making (Fitzgerald, 2020; Monrouxe, 2010) is a testament to its perceived personal, social, and institutional value. International studies have explored identity-making for nurses and midwives rather broadly. Halverson et al.'s (2022) addresses literature's "vague conceptualization" (p. 12) of nursing

professional identity through a concept analysis for the Canadian Association of Schools of Nursing. The authors offer seven attributes for the concept of nurses' professional identity:

> […] internalized values and ideas, a sense of self that is derived and perceived from the nursing role, professional identity as a component of overall identity, engagement in duty and responsibility responsive to public interest and a concern for achieving social ends, perception of self that is influenced by the image of nursing, knowledge of what the role entails, and feelings of self-certainty in the role. (p. 12)

A scoping review by Cornett et al. (2023) contributes an understanding of trends in research conducted on professional identity within 32 health professions and explores the range in how professional identity is described. These authors found that identity-making studies in medicine and nursing were most common. International studies on nursing identity are interesting for considering the multiple contexts including norms and values that impact nurses' professional self-concepts (e.g., Losa Iglesias & Becerro De Bengoa Vallejo, 2011; Öhlén & Segesten, 1998; Soerensen et al., 2024).

Professional nursing identity has been explored both internationally and domestically through varied methodological approaches. MacIntosh's 2002 doctoral study and subsequent publication (MacIntosh, 2003) of 21 nurses working in the Canadian maritime provinces explores their experience of "being professional" (p. iii). International studies such as Thompson et al.'s (2018) hermeneutic phenomenological study examines the nursing home setting and role in the tenuous formation of nurse's work identity. In another atypical work setting (i.e., the nurse-led call-centre), Snelgrove (2009) used a questionnaire and focus-group discussion, identifying nurses defending their identities as nurses rather than that of a call-centre worker. To do this, the author describes that they draw on past experiences and the ability to retain holistic,

empathetic practices in their current setting. Diede's (2018) doctoral dissertation illustrates use of a philosophical hermeneutic phenomenology and one-to-one interviews to deeply examine American hospital nurses' lived experience of professional identity. International studies on midwives' identity-making add similar richness, considering both student and registrant experiences (e.g., Kraienhemke, 2021; Larsson et al., 2009; Vincifori & Min, 2014; Zhang, 2013; Zhang et al., 2015).

Using various qualitative research methodologies, several studies conducted outside of Canada examine professional identity in practitioners who are educated and practiced both as nurses and midwives. Jayathinlake (2016) present research focused on the identity-making experiences of midwifery-trained RNs in Sri Lanka. The author explores multiple contexts including this group's lack of defined role and unique professional title, and their experiences of interprofessional hostility from direct-entry RMs and general RNs. Caldas et al. (2016) conducted a thematic analysis from in-depth interviews comparing 10 nurse midwives' perception of their professional identity in hospital versus birth centre settings in Rio de Janeiro. Additionally, some publications examine the lived experiences of American Certified Nurse Midwives' (CNM) associated meaning-making of their hybrid professional identity (see, e.g., Barker Caza & Creary, 2016; Dawley, 2005; Foley, 2004; Scoggin, 1996). Following interviews, Barker Caza & Creary (2016) assert three personal strategy themes for how participants structure their CNM professional identity: intersection (i.e., being and working "in-between" (p. 18) the dominant American social identities of radical, natural midwifery and medicine-focused nursing); dominance (i.e., one professional identity takes priority over the other); and compartmentalization (i.e., only one identity enacted at a time). Each of these studies offer windows into nurse and midwife identity-making within the particularities of their study setting;

however, there are none exploring the unique historical, professional, social, and personal contexts in which the minority group of Canadian midwives who are also nurses experience their lives.

Professional Identity-Making in Narrative Inquiry

Identity is conceived narratively as "internalized and evolving life stories" (Chase, 2011, p. 422). Clandinin and Connelly (1999) describe that from a narrative stance, “identities have histories” (p. 95) that evolve with the passage of time, and tend to be situationally, contextually, relationally multiple. They add, “[t]he identities we have, the stories we live by, tend to show different faces depending on the situations in which we find ourselves” (Clandinin & Connelly, 1999). Constructing the self within multiple contexts, including institutional and cultural, occurs within the creative space of stories. Within stories, identities can be asserted, rejected, and reimagined. Blix et al. (2019) explains, “[o]ur stories are of great importance; through the stories, we each tell, we construct who we are and what we are becoming, that is, we shape our past, present and anticipated futures” (p. 1918). The relational aspect of story telling (tell to, telling with others) contributes another quality to ongoing identity construction (Blix et al., 2019).

Midwifery and Nursing Identity Examined Narratively.

Most narrative inquiry research on the topic of professional identity appears to be published in the areas of education (see, i.e., Clandinin & Connelly, 1999; Craig, 2011; Reid, 2017); however, there are a small number in the English language that pertain to nursing and midwifery. For example, Mulcahy (2006) uses a narrative approach in their master’s research to explore experiences of dual RN-RM registrants in New Zealand as they choose their career path following regulatory changes in 2003 that separated nursing and midwifery. Prior to separation, dual registrants had been able to move “freely between the two professions” (Mulcahy, 2006, p.

4) but these new regulations created a division with new restrictions and structures to contend. In the author's narrative study of three participants, they explore the "intertwined persona" (p. 5) of nurse and midwife through questions of professional socialization, self-definition, and professional identity. Mulcahy (2006) draws on symbolism and myth of the hero's journey throughout the analysis.

The most intentional application of narrative inquiry methodology to the topic of professional identity and midwifery emerged from Asamoah Ampofo's (2018) doctoral research exploring "Ghanaian midwives' experiences of caring for women during labour" (p. i). By relationally inquiring into the stories of four practising midwives, the author identifies a three-part resonant thread pertaining to midwives' professional and practical knowledge landscapes. Later, Asamoah Ampofo et al. (2022) use narrative understandings from the five months of conversations during the aforementioned research to explore professional identity-making in Ghanaian midwives. Here, Asamoah Ampofo et al. (2022) underscore life experience themes (i.e., childhood, education, and professional work) as primary forces shaping the evolving process of professional identity-making. This disrupts a common narrative that the formation of midwifery identity is a static product of the socialization and education in midwifery education programs. The author proposes that these findings, which are derived from tending to social, temporal, and locational contexts of participants' stories, have implications for how this subject ought to be attended in midwifery education programs and in research.

Chapter 3: Methodology

After considering the social and historical contexts through a literature review, I return to my primary query that has not been explored previously: the experiences of dual educated and practiced Canadian RMs who have also been Canadian educated RNs working in areas of maternal-child health. In this chapter, I will introduce my proposed methodology: narrative inquiry. I review its ontological and epistemological foundations, and my rationale for selecting it for this research puzzle. I explore how professional identity-making is contended narratively before elaborating on my proposed research methods. Lastly, I detail ethical obligations and relational commitments within the spirit of relational ethics.

Narrative Inquiry

The qualitative research methodology, *narrative inquiry*, provides a structure for inquiring into human experience and for understanding experiences as told by those who live them (Chase, 2011). Scholars of narrative inquiry contend that focusing on lives, including the everyday of ordinary people, allows for meaning-making (Chase, 2011). There are several features that distinguish narrative inquiry from other methodologies that also take an analytical approach to narratives and use human stories as data for understanding the phenomena of interest. Narrative inquiry uniquely centers participant-researcher relationships while tending to the influences of time (past, present, future); place; and compounded, multidimensional contexts (Clandinin & Caine, 2013). Rather than seeking "to generalize from specific contexts to broader concepts, or to impose theoretical concepts on people's stories" (Chase, 2011, pp. 421–422), narrative inquirers focus attention to understanding each story in collaboration. Here, "the local and specific" (Clandinin, 2007, p. 1) drive the researcher's curiosity rather than the universal. This methodology requires attentiveness to manifold relationships, and takes a contextual view

of experience in which the researcher inquires into the multiple layers of "social, cultural, and institutional narratives" (Clandinin & Caine, 2013, p. 168).

Chase (2005) explains that narrative research has historical roots in the liberation movements of the 1960s and 1970s that turned attention to life history methods, and to the second wave of the women's movement that oriented to personal narrative study. Feminist contribution to this research methodology includes considering the role of power and the researchers' own positionality within the research relationship (e.g. whose questions get asked and answered; who has the final say) (Chase, 2005). The discipline took shape with a particular appreciation for the lived experience of ordinary people in everyday life in snapshots rather than "full-fledged life histories" (Chase, 2005, p. 655).

Ontology and Epistemology in Narrative Inquiry.

Narrative inquiry is "both methodology and phenomena" (Clandinin & Caine, 2013, p.168) with early influences from education, anthropology, sociology, medicine, and philosophy. Dominant philosophical influences include John Dewey's pragmatic theory of experience and Jerome Bruner's paradigmatic and narrative knowing (Clandinin & Caine, 2013). There is variance in how narrative inquirers position their work within their evolving discipline. In Clandinin's (2007) *Handbook of Narrative Inquiry: Mapping a Methodology*, she highlights the divisions between how narrative inquirers understand the nature of knowledge and reality. Clandinin (2007) offers *experience* as the cornerstone that ties narrative inquiry scholarship.

Primary ontological underpinnings of narrative inquiry converge on dynamic human experience (further, human constructs of evolving identities) as inherently narrative. Reality is constructed, negotiated, reconstructed in relationship with ourselves, each other, and the many contexts we contend through the stories we tell, live, retell, and relive (Caine et al., 2013, p.

574). Epistemologically, narrative inquiry credits composing and recomposing stories (which flow from experience and relationships) with knowledge construction. Caine et al. (2013) underscore the narrative inquirers' primary epistemological commitment, in that "experience is knowledge for living" (p. 576). Because characteristics and quality of each story shift in response to contexts, aligned with its pragmatist roots, narrative inquiry holds space for multiple realities that are expected to shift and reshape with time, place, and relationship (Blix et al., 2019).

Rationale for Narrative Inquiry Methodology.

I consider narrative inquiry methodology to be particularly well-suited for addressing the experience-centred wonderings I present in my research puzzle as well as for the specific population I am curious about. Queries such as mine that centre around questions of life stories and identity may be amply addressed by a range of qualitative methodologies; however, the features of narrative inquiry methodology that specifically support the nature of this project include a relational focus, conversation (versus interview), and co-composition of texts. As a professional group, Canadian RMs affirm common values of partnership, continuity of care relationship, collaboration, as well as "the interactive process of informed choice" (Canadian Association of Midwives, 2015; Midwifery Regulatory Council of Nova Scotia, 2022, p. 1). Their model of care and regulatory standards emphasise compassion, respect, listening, and trust within care partnerships (College of Midwives of Ontario, 2020). I believe that the multiple methodological commitments (Caine et al., 2013), and relational ethics and responsibilities (Caine et al., 2020) that are essential to narrative inquiry will align well with the expectations of participants.

I am aware of dominant discourses about midwives and nurses as I have been steeping in them for my 18 years of practice. I sense how limiting and stagnant these representations can be.

Instead, turning toward experience will allow for richness, nuance, and dynamism. I am aware that narrators telling their stories will also be contending dominant discourses; yet, participants and I can work within a more flexible space to explore possibilities by imagining differently together.

Participants

I recruited four participants who had completed both an undergraduate degree in nursing and undergraduate degree in midwifery in a Canadian institution. To be eligible to participate, they must have practiced for at least six months as a registered midwife and as a registered nurse in an area of maternal-child or perinatal health. Participants were not required to be currently practising in either role; although, it turned out that each of the four were practising midwives at the time of their research engagement. While many registrants may be internationally educated and experienced in the other profession, I intentionally sought graduates from Canadian models of care as this is an unstudied area with a unique set of overlapping features.

I prepared and planned to disseminate recruitment material (i.e., postcard and short introductory summary) via the electronic distribution lists of several provincial and territorial midwifery professional associations from which I had gained written support; specifically, the Midwives Association of British Columbia; Midwives Association of Saskatchewan; Association of Nova Scotia Midwives; and Association of Midwives of Newfoundland and Labrador. With written support of the group administrators gained November 15, 2024, I planned to post the ad to two Facebook groups: Canadian Registered Midwives (1.3k members) and Life After Midwifery (749 members). After making my first post of recruitment materials on December 29, 2024 (to the Canadian Registered Midwives Facebook Group), the robust response was sufficient to end recruitment earlier than anticipated and without further dissemination. Because I

anticipated that participants would not be familiar with some qualities of narrative inquiry methodology compared with dominant research approaches such as survey or thematic analysis, I expanded on these in the accompanying introductory summary, consent form, and in direct exchanges with potential participants. I offered a $30 honorarium per conversation to each participant in addition to refreshments.

Gathering Field Texts

I offered all potential participants an introductory meeting to learn about the research study and to review the consent form and research process together. Then, I invited those who provided signed informed consent to participate in a series of three to five one-hour conversations to be conducted in-person, by telephone, or via video conference, as negotiated between each participant and me. All participants elected video conference, and the conversations lasted between 40 and 90 minutes. I attended to confidentiality requirements throughout as per research ethics board requirements. I anticipated asking participants guiding questions that indicate the scope of work such as, "Tell me about how you came to nursing and midwifery"; "I'd love to hear about your education and practice history" (see Appendix C); however, the conversations largely flowed without prompts. Conversations evolved as rapport was built and basic information was exchanged. Within conversation, I, as researcher with my personal wonderings and experiences, contributed alongside with each participant. Our respective contributions and the evolving whole of our conversation were held as the research focus of our engagement. For example, at times we discussed what has stood out to us as Canadian practitioners as we navigate our own version of a constructed dual professional identity in our respective practice contexts.

The purpose of the second and subsequent conversations was to build upon my relationship with the participant in a way that deepened our shared understanding being negotiated. It was also to provide both the participants and me time between visits during which we developed new understandings of the topics when in other contexts at other times. Narrative inquirers respond to what scholars such as Clandinin and Connelly (2000) call the three-dimensional narrative inquiry space. This incorporates "temporality" (acknowledgement of past, present, and future); "sociality" (attention to contributor's inner emotional, moral and intellectual experiences); and "place" (the location of life events and of the researcher-participant engagement itself) (Clandinin & Caine, 2013). I was open to participants sharing photographs, documents, and any other artifacts they wished to share to express their experiences. Some participants integrated photographs, art, or visuals of their physical surroundings into our conversations.

Progressing Together to Interim Texts

Following each conversation, I transcribed using the automatic speech recognition system, Whisper. I ensured storage met requirements outlined by the research ethics board. I referenced these transcripts as I composed tentative narrative accounts for each participant. These narrative accounts were flexible in format. They served as personal ways to express my evolving understanding of what was shared within each meeting while also drawing on my attunement to silences and settings. As Blix et al. (2021) emphasize, narrative inquirers "need to be wakeful to what is told and also untold, often simultaneously" (p. 1). Each of the four narrative accounts came in a unique form (i.e. memos, travelogue, diary entries, and letters) composed to reflect the relationship built with the specific participant. When offering each participant these narrative accounts, I invited their assessment of my interpretation. First, I

emailed a partial draft of six to eight pages, asked the participant to reflect on the tone and style as a way of representing their stories, and then we met to discuss their impressions. Each clarified and elaborated on some areas and gave feedback for me to consider in shaping the next stages of the draft.

At this point, we progressed to co-composing final narrative accounts. Once I had completed a first draft of a participant's full narrative account, I sought my supervisor's feedback, made corresponding adjustments, and then emailed the revised draft to each participant with a request to coordinate another meeting. Each participant and I met once more to review areas needing further attention. This meeting included discussing personalized strategies for anonymizing their accounts including with the use of a self-selected pseudonym and depersonalizing locations. Once all edits were made that met participants' satisfaction for representing their experiences in writing, they each provided verbal or written approval to finalize their narrative account. The final narrative accounts became the basis for me to look across participant encounters for resonant threads that connected them.

Co-compositions by participants and researchers are intertwined with each contributor's individual and relational experiences (Clandinin & Caine, 2013). I invited ongoing dialogue with participants, fostering an openness to continued engagement over the five months of this project. At the outset of the project, I was cognizant that I could not ensure the equal and continuous engagement of each participant. Instead, I favoured their free choice to engage the research relationship and project to the degree they desired. I expressed ongoing attention to their needs as research participants. I feel fortunate that each participant maintained committed involvement throughout the research process. The second level of analysis (i.e., resonant threads) have become final research texts in this master's thesis dissertation available for public access.

Chapter 8 is written to submit for publication, with the potential for additional publication from this data in the future.

Touchstones of Quality Inquiry

Narrative inquiry is a methodology well suited to examining the multiplicity and complexity of human experience (Clandinin & Caine, 2013). The positivist terms trustworthiness and rigor are not aligned with ontological and epistemological foundations of narrative inquiry; rather, there are twelve touchstones (Clandinin & Caine, 2013) which serve as surrogates that I attended in my research process to guide quality work. For example, the initial stages of my proposal involved autobiographical writings (i.e., my Narrative Beginnings). Writing this section entailed an introspective process wherein I attempted to understand my own curiosities about my research puzzle by situating myself within it. These efforts of exploring my personal connection to the topic adds a form of trustworthiness because it avoids a false claim to objectivity or impartiality. I am acutely aware of my proximity to my research puzzle and the likelihood of real or imagined “overlapping stories” (Caine et al., 2013, p. 574) between myself and participants. I cultivated a sustained curiosity about how these are manifest in the research relationships. The questions threaded throughout my own stories along with the sociopolitical and historical detail in the Narrative Beginnings help to justify the subject of my inquiry.

To attend to human experience and research relationships “in the midst” (Caine et al., 2013, p. 575), I have been sensitive to the temporal, relational, and locational qualities affecting each level of ongoing and interwoven participant and researcher narrative. This includes political, cultural, social, and institutional narratives of nurses and midwives, and the multiple co-existing identities and occupations we each contend in our daily lives. Attuning to these layers of context also improves the quality of this inquiry. Additionally, the combination of my

narrative beginnings with the literature review on the historical, social, and political factors shaping the development of the Canadian nursing and midwifery professions renders contexts more evident.

Part of ensuring high quality research in this methodology is keeping in mind that the intent is not to come to conclusions or final answers on questions; rather, it is to rethink human experiences in a relationally ethical, collaborative way. I acknowledge that growth and evolution of participant and researcher identities continue beyond the active research relationship. Given the small sample size and the ontological and epistemological orientation of narrative inquiry, generalizability is not an appropriate aspiration. Blix et al. (2019) highlight Randall's explanation of memory that they are not an unadulterated replica of what took place; rather, they are a combination of fact and fiction that are adjusted for the context and relationships in which the storytelling transpires. Clandinin and Connelly (1999) add, "although we may mistrust the veracity of memory as an empirical record, we celebrate it as a revealing narrative construction" (pp. 95-96). I did not aim to ensure that narrators recount actual events in precise ways; rather, I have been curious about the meanings they attach and remained open to multiple interpretations (Chase, 2011).

Negotiation and co-composition of texts are important techniques for improving the quality of this work. Instead of member checking, narrative inquirers involve participants, and people who have become part of the research in other ways, in the creation of all iterations of interim research text. I have involved my supervisor and committee member and master's tutorial classmates as types of response communities in this work.

Ethical Considerations

I had numerous ethical obligations to tend to throughout and beyond this research study. To begin, I was obligated to consider the justifications I have forwarded for this study including deep personal curiosity on an unstudied topic to which I am intimately connected. Additionally, I attempted to address the need for understanding human experience of dual RM-RN professional identity-making to inform advanced education institutions and professional bodies. For example, Clandinin and Cave's (2008) narrative inquiry on the development of doctor professional identity offers insights about the value of creating pedagogical spaces for strategically facilitating professional identity-making through narrative approaches. Additionally, I aimed to offer more sophisticated understanding of experience which may support retention and professional satisfaction. Ultimately, as anticipated, I have revealed areas for future inquiry. Revisiting these justifications throughout the project, including conversing over them with participants and fellow scholars gave me additional perspectives to consider. I found that the reasons for conducting this study, and its areas of potential value and contribution shifted to a degree thanks to the research relationships, and negotiations over texts and resonant threads.

Because the relationships between researcher and participants are central to narrative inquiry methodology (Clandinin & Caine, 2013), I upheld principles of relational ethics and "relational responsibilities" (Clandinin & Caine, 2013, p. 169) throughout the research process. During our introductory meeting, I directly described my interpretation of my ethical and relational responsibilities with participants and invited their expression of needs and preferences. I have been mindful of my short- and longer-term ethical obligations to my participants and their stories throughout our active research relationship and beyond. I took time at the outset of the research relationship to carefully explain the nature of the methodology and revisited this at new

stages. This included the personal depth into experience and identity that was anticipated throughout the inquiry process; the ongoing nature of the research relationship; and the presence and limits of consent. While the group of participants and meeting locations I proposed were not especially vulnerable, I recognized the potential risk of discomfort or exposure due to the length of the published narratives. I could not know what participants would share with me or how our conversations would affect them. To mitigate potential harms, I offered all participants the opportunity to review their interim texts and adjust them. Later, at the stage of writing narrative accounts, I reconnected with participants to review and revise these passages according to their interpretation and comfort. I revisited and reassessed participants' permission to represent them in proposed ways, reminding them that permission can be revoked up until we collaboratively finalized narrative accounts. All four participants authorized the inclusion of final narrative accounts in this master's thesis.

Relational Ethics

Narrative inquiry is a relational research methodology that is rooted in principles of relational ethics. The relational responsibility and commitment to relational ethics prompts me to centre questions such as *Who am I? Who are you? How should we be with one another?* throughout the research relationship. Clandinin and Caine (2013) explain that narrative inquiry spaces are shared belonging spaces for both researchers and participants in which all contributors bring "attitudes of openness, mutual vulnerability, reciprocity, and care" (p. 169). Bergum (2004) asserts that "relational space, as a moral space, is where one enacts responsiveness and responsibility not just for oneself *or* for the other, but within the space of being for and with both oneself *and* the other" (p. 486). In the research relationship, I gave careful attention to these basic questions that grasp at each contributor's place, identity, and relational autonomy.

Chapter 4: Narrative Account for Kristen

Kristen was one of the first people to respond to my call for participants—an encouraging moment for me as a new graduate student researcher. I hoped that my interest in the lived experiences and professional identity of Canadian Registered Midwives who have also been Canadian maternal-child nurses would speak to others but was not sure how recruitment would unfold. Kristen reached out to me by email with a thoughtful question about my study and later offered to join. I had the privilege of meeting with her over two months for four 1-hour conversations held virtually over Zoom. I delighted that Kristen was often in a new location in and around her home when we met. This felt like a generous offering of additional windows into who she is to then combine with the significant ways she took me through memorable times in her professional and personal lives.

I started this first draft after our third conversation to offer a way to communicate Kristen's stories. I struggled with the tension around a desire to create a fulsome and chronologically coherent narrative. I reread transcripts and my margin notes asking myself, "Kristen, where are you and what is important to you?" and I negotiated with my urge to make events linear as though one leads to another in a meaningful way. Yet, there were many patchy areas in this participant's nursing and midwifery stories, blank spaces in the timeline that we may or may not get to in our period together. These areas may not be accessible, they may not feel important, or both. Or is it something different? What do the absences have to teach?

I note that there are early parts of Kristen's story where we can't quite fill in gaps together. It isn't until the final minutes of our third session, three weeks after we first met, that I learned that she had attended her first births as an 18-year-old, and that she had completed doula training which taught her skills in labour support. Both feel to me like strikingly important

features of a nurse midwife identity story, yet they enter our conversations as though they are afterthoughts. This makes me question their place. Perhaps the memories Kristen has offered so far are linked by something different; perhaps the order and way that they surface offer something to be curious about.

We address these questions together directly as we begin negotiating these texts during our fourth encounter. Kristen suggests that she could likely pull together a more comprehensive timeline if she dedicated herself to pen and paper. I am tempted to assure her that it isn't necessary and that a sort of looseness brings its own value. We acknowledge together that she's raised chronic sleep deprivation (a side effect of a nurse and midwife's employ), motherhood amnesia, and perimenopause at several times in our conversations. Though we had previously shared laughs over the mutual familiarity of each of these features; in discussing my writings of Kristen's memory, I am drawn to pause and give a more respectful space to their deeper impacts.

As we end the shared storytelling which by now has filled in some patches and left others untouched, I am struck most by my sense that Kristen appears to hold a deep, innate knowledge of who she is that has held steady over time and throughout complexly changing external circumstances. She has experienced varied and extensive education; motherhood; living and working internationally; and numerous practice settings and roles. Presenting Kristen's stories as a series of memo fragments in rough chronological fashion represents my attempt to turn attention to memories that she emphasized while tending to the consistency of her values and sense of self.

Memo Fragment #1: Earliest Stories

Early awareness of her Dutch heritage.

Growing up listening to her parents' stories of Dutch midwives.

The Ontario government legislated midwifery in 1993.

Paid attention to circulating news stories.

During our initial introductions and before I pressed audio record, Kristen offers me a quick surface review of her journey through nursing and into midwifery. I was curious to start at the roots and move slowly through her earliest stories. Once I began recording, I asked if Kristen would like to return to the words she had spoken minutes before: *I wanted to become a midwife*[4]. From there, Kristen recalls her international nursing work in Central Africa where she began to take notice of a mismatch between adequate skillset and inadequate confidence and autonomy. *Maybe it was just a title that I needed or a hat, a different hat to be able to offer the kind of care I wanted to offer.* I note my efforts in subsequent conversations to rewind the clock even further to an earlier time once I learned that Kristen had in fact applied to a Canadian midwifery education program twelve years prior, in 1993. Her experiences around the time of her work in Africa were pivotal, and yet this midwife origin story has a longer history than comes immediately to her mind.

I was struck that Kristen knew about Canadian midwifery from the time of regulation in her province. I asked her where those initial messages came from that taught her that midwives practice in Canada and that she could be one too. *Yeah, I do remember because it was a news story because it was legislated. And in Ontario, the way the midwifery came about was unfortunately through a bad outcome.* She recounts a snapshot that I was familiar with from my readings on modern midwifery history in Canada. An infant death associated with a homebirth provided the impetus to establish a midwifery education program, legislate midwifery practice, and establish access to hospitals and associated supports for registered midwives and their clients. *It was a home birth that had a poor outcome. And the midwife said, well, if we had*

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[4] Note: All *italicized statements* are direct quotations of the participant. Words in italicized *ALL CAPS* are those that were emphasized by the participant within a statement.

access to bring this person to the hospital, this possibly wouldn't have happened. So yeah, I heard that on the news. I retain my curiosity over "why midwifery"? Of all the topics one hears on the news, why did this vocation catch her interest?

After more discussion, Kristen locates her earliest midwifery memories. She recalls stories her mother and father told her about her Dutch heritage and the Dutch midwives in their family. Kristen explains that she affiliates with *the way midwifery happens in the Netherlands* more than that from the United Kingdom. *I grew up hearing my parents' stories and how the midwife rode her bike or her motorbike to my parents'—my grandparents' home—to help with all of those births.* Kristen pauses as a key piece of her history comes into view. She reflects on her father's stories of the Dutch midwife who attended his own labouring mother who pulled up to the house on a motorcycle and wearing leather chaps. Later the midwife stayed to fold baby clothes. While Kristen now questions how roles were divided among different tiers of Dutch midwives or personal health workers, she recognizes that these family stories preceded the influence of a key mentor Ada, a South African educated midwife practising in the early days of regulated Ontario midwifery.

Here I became more curious about the root of Kristen's pull toward autonomy and confidence to offer families choice over following protocols. When asked directly, Kristen supposes that her attunement to the concept of informed choice, which she highlights as core to her practice, likely developed within her later. *I think that came later because I actually remember in my family stories those midwives were very bossy. And I don't think there was a lot of informed choice happening from what I recall in those stories. The midwife just basically told you what was happening, and you did it.* I recalled my own mentors who were UK educated midwives now working as Canadian obstetrical nurses. I was drawn to their confidence and

sense that they overrode the hierarchy, and so often acted boldly on “the right side of wrong”. They did not need to offer patient choice to inspire me; rather, it was something else about how they were being and doing differently. As I speak with Kristen, I find myself reflecting upon autonomy with respect to client and midwife independently, and then as a collaborative unit. Similarly, I find myself for the first time considering informed choice as a concept independent from autonomy as part of a midwife’s professional identity. While I learn from Kristen’s reflections over time that both are core to her own identity, they can be tended to separately.

Memo Fragment #2: Stepping Toward Birth Work

First Canadian midwifery education program opens in 1993. Entry of experienced applicants prioritized.

Applied to midwifery education program.

Denied entry.

Recommended to get more experience. *Okay then, I will.*

Attended 1st birth (cousin) at age 18.

Did doula training.

Attended a few births.

Completed a degree in psychology.

Kristen shares that she first applied to the newly established midwifery education program in her province in 1993 while in her first year of studying kinesiology and was denied entrance. She explains that in that first year, *they were grand fathering—[chuckles] I think they should say grand mothering—all the existing midwives in, and they said you didn't (...), you need to go get some experience. So then I realized, okay then I will. I will go and get some*. She identified doula training as *the next best thing I can do*; she signed up to gain knowledge and skill to be a non-clinical labour support worker. Though I repeatedly share my surprise that she became a doula in her late teens which strikes me both as very young and as a noteworthy philosophical and practical introduction to childbirth care, she does not underscore her doula education or experience in any way. *I guess I just did that to kill time before I could get into some other program*.

While Kristen does not believe she attended many births as a doula, I learn that she went to her first birth when she was 18 years old; probably during her doula training she says, and that it was her pregnant aunt. *I asked my aunt, can I come to your birth? And she said, "yeah, no problem." And the doctor—I think the doctor was also my mom's, probably caught me when I was a baby. Everybody used the same guy. He asked, "oh, what size are your hands?" And I thought, why would you want to know what size my hands are? So I just held them up and he said, "oh, you're a seven." He gave me size seven sterile gloves. And he said, "just do this." And it was her third baby so it just came out into my hands. Nothing eventful. But I'm like, I'm a size seven glove! I think that's the biggest deal that I took away was now I know what size of gloves I need for my future career. That was the gift that he gave me.*

Memo Fragment #3: Turning Toward Nursing and International Travels

Thoughts of becoming a pediatrician later dismissed.

Tanzania. The first of many international trips.

Elects a diploma in nursing.

More details trickle in in random sequence. Early in our conversations, I learn that Kristen had originally wanted to become a pediatrician but later dismissed them in part due to *a very strong sense for wanting to look after healthy, well women and babies*. At some point she switched her undergraduate education from kinesiology to psychology. She went to Tanzania to conduct environmental research. *I took a lot of breaks.* She chose to apply to a nursing program though the specific timing and reasoning allude our conversations. *I did a diploma in nursing, realizing that I didn't have to get a degree in nursing because I wasn't staying in that capacity.* I am fascinated that these details emerge so unassumingly; I sense that they are spoken by someone for whom deeply ingrained values and beliefs about herself go without saying. Perhaps these features are taken for granted in midlife when a career is well established. Or perhaps we are still searching together for language. I continue to ask myself, “Kristen, where are you and what is important to you?”

Memo Fragment #4: Becoming a Nurse & Meeting First Midwives

Began nursing diploma.

Graduated from nursing in 2001

Consolidation semester on postpartum and labour & delivery.

Hired into first nursing job.

Met first Canadian Midwives. “Ada”

I learned nothing about Kristen's experiences of nursing education; she does not share stories from nursing school or practica. She offers that she completed her consolidation semester at a very busy Canadian obstetrical unit and was hired after graduation in 2001 on the same unit. *And that's when I met the first midwives that I met because they were working at that same facility. And there was a woman called Ada from South Africa, and she was a real hoot. And I really enjoyed working with her.* Ada told Kristen about the work of South African midwives: *nurses and midwives are pretty much doing the same job. And then I realized, oh, well, that's the job that I [with emphasis] want to do. I don't want to have to call a doctor. I don't want to do all the work and then call a doctor at the end, and they can poorly catch this baby when I possibly could have done not necessarily a better job—but at least afforded that continuity and that—without changing the energy in the room*.

After our second conversation, I spent a night at the library writing Post-It notes with highlights from the two hours of transcript. I mixed and moved, trying to piece together a timeline. I wanted to understand Kristen's journey more clearly and assess my own interpretation against her sense of her truths. I sketched out a map in pen and crayon, linking the Post-It notes that contained events and quotes that had stood out through emphasis or repetition. I hoped that creating a visual depiction would support the emergence of new memories or clarity. Simultaneously, I felt cautious that an overemphasis on a linear timeline may be disruptive to her sharing experiences authentically. Kristen received my colourfully sketched offering positively. She wrote back with an insight that brought new language and clarity that bring pieces of her professional identity into better view.

Memo Fragment #5: Work as an Obstetrical Nurse and Working Alongside Midwives

Works several places as OB nurse

Nurse Kristen.

Being the nurse assigned to midwife cases. Aligned values.

Kristen worked in several Canadian hospitals as an obstetrical nurse, including briefly as an agency nurse. She found the latter interesting but not enjoyable due to frequent moves between sites. *You don't get a lot of respect from the staff nurses. Because you come out of nowhere and you're getting paid more than they are in hour. And then maybe you never come back again. And you don't know the protocols and you don't know the flow.* One site she particularly enjoyed working as a regular staff nurse was notable for its multicultural staff and patients. The diversity of the situations presenting to the unit made *following the script* that she opposed, impossible. She describes the variety of sociocultural birthing practices, beliefs about postpartum and baby care that taught her about a wide range of human beliefs and priorities around childbirth.

I felt compelled to better understand Kristen as an obstetrical nurse before she began midwifery education, when perinatal nursing was the only clinical role she knew. I tried in different ways to inquire into these times. With more self-reflection, I suppose I was searching for evolution that I had assumed must have been there; as though I could not imagine that beliefs, values, and self-perception could be stable over time through such different practice cultures. Acknowledging that two decades had passed, I asked if she could feel that person anymore who was in the labour room with her patients doing her nursing job. *I remember that she was also protecting people from obstetricians and sometimes other nurses. Yeah, or like, in her head, telling people, "Stop doing that," or "stop, stop (...),"—yeah, just thinking, "gosh don't, don't DO that TO that person." Unfortunately. Or witnessing, probably witnessing abuses as well and feeling powerless to do anything about it— except becoming an autonomous primary care provider and help other people to have the birth that they want without being told they have to push on their back, without being told they have to have an episiotomy, you have to have forceps.*

Kristen protested the culture of nursing staff robotically following protocols without *applying common sense*. As she speaks, I wonder if following protocols as *very well programmed* nurses is a valued part of some nurses' professional identities; albeit problematic. It is something I relate to, ashamedly, myself.

Kristen paints a picture of being different from the dominant nursing culture insofar as she preferred to be *with woman* throughout her nursing career. Rather than chatting at the desk with the other nurses who observed their patients through centralized electronic fetal monitoring, Kristen stayed at the bedside. She describes feeling connected with some other staff nurses who shared her interest in midwifery, though also generally had a sense that obstetrical unit staff did not know quite what to do with her. *I can remember a woman that gave birth in the same room that I gave birth in. There was this corner room, and I always said if I have a baby in this hospital this is the room I'll be in. I was with her, and she refused (…)— she said whatever I say I do not want an epidural, I don't want any drugs. And she screamed and— I remember she was a curious person— there was blood all over the place because she didn't want to be in the bed. And I remember I could hear people out in the hallway saying, "What is Kristen DOING in there?!" and I remember thinking to myself, "For goodness sakes, it's not ME. I'm not the one screaming! They wondered, "Why doesn't she come out and ask for help or something?" I said, "Everything's okay. I would let you know if there was a problem in here." And then eventually I think the OB just came in said "Listen! You just have to do it like this and then it can be over!" Anyhow, she wouldn't listen to him. I was actually secretly probably laughing at him because she's doing what she wanted to do and it worked out fine.* There is resonance in this story for me despite no concrete personal memories. Listening, I experience a familiar sense that as a nurse I

had also been asked to control my cases to fit a form that was not flexibly shaped enough to ever feel right.

Obstetrical nursing also gave Kristen opportunities to work alongside midwives who presented to hospital for care of their pregnant patients. *If a midwife couldn't get their backup on time, they would call a nurse to a birth. And I often was the one that they called in because they realized that our values aligned, and that's how I got to observe. I saw, wow, a woman doesn't have to push a baby out on her back? Wow, she can eat in drink and labor. I just got to observe it by watching how these other midwives work. And then I actually did incorporate that into my nursing practice, but the physicians didn't like it.* Stories of Kristen's indignation with and resistance to dominant medicalization of childbirth begin to amass in our third and fourth conversations. I am developing a more refined outline of who Kristen is of which she may have had an intuitive sense of knowing from the start: extending beyond advocacy, Kristen is a long-standing protector of patients from the prescriptive and interventive forces common to obstetrical units; she deeply values her own autonomy which is essential to fulfilling her resolute commitment to patient choice.

Memo Fragment #6: Reapplying to Midwifery

Stories from nursing work that prompted the decision to reapply to midwifery education.

Africa with Doctors without Borders in 2005

Applied again to a midwifery education program.

Accepted into expedited program.

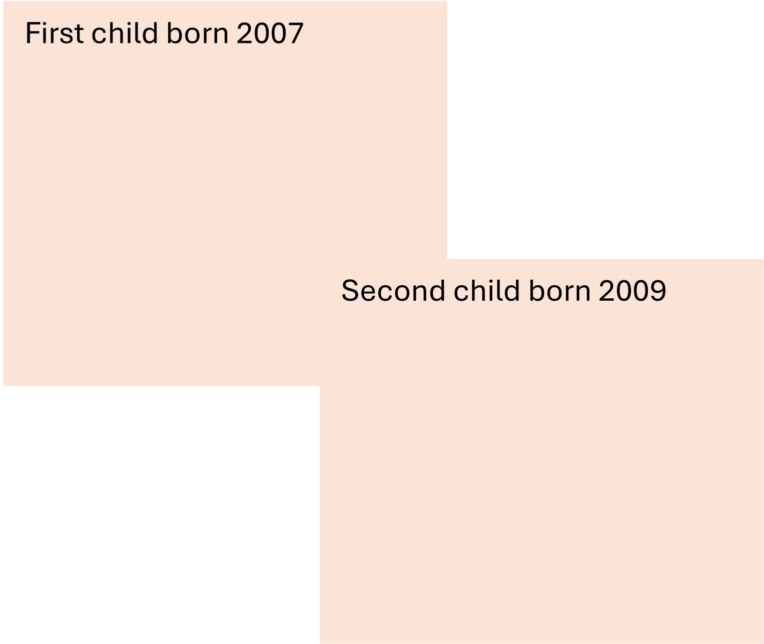
Continued obstetrical nursing while in midwifery education.

As we started to negotiate the format of this narrative account and honed our conversations toward transition times in Kristen's nurse and midwife lives, she wrote to me in an email about her decision to reapply to the midwifery education program. *I recalled as an RN at [a Canadian hospital] I was pushing with a patient and wasn't aware the call bell wasn't working. That's what we used to let the OB* (obstetrician) *know it was time to come into the room. The patient was crowning and I had to ask her husband to run down the hall to get the OB to come catch because nobody was responding to my call bell. Same OB yelled at me later for not calling him sooner. I remember asking him "do you really think I wanted this woman to have such a panicked last few minutes of her birth??" Not long after this I was pushing with a different person and when I pushed the call bell, the charge nurse came to tell me the OB was busy and wasn't coming and instructed me on how to catch the baby myself. After that I realized that for 90% of these patients we didn't need an OB and that I could do a better job myself and thus the transition to midwifery began in my head. That's when I signed up with Doctors Without Borders and upon return from that trip to [Africa] applied and was accepted to the midwifery education program.*

I was curious how being an experienced labour and delivery nurse impacted Kristen's application, recalling that she had been told after her first attempt to go get some experience. *Well, I recall when I was applying to [a Canadian] midwifery education program, I was told they will never—as a labour and delivery nurse, they will never let you in. Because nurses have preconceived ideas about how a birth should go and nurses just can't deviate from that. But fortunately, the chair of the program was also one of the midwives that I worked with at the hospital. So she knew me. I was always a nurse that she would call into the birth if she needed something. So she knew that wasn't true of me and then they realized, okay, we obviously can't*

make assumptions about all nurses here. And so I think, I think I was one of the first labour and delivery nurses to be admitted to the program. Because of her previous degree, Kristen received advanced standing and was given an expedited course schema.

Memo Fragment #7: Birthing Two Children



Kristen and I hover over the timeframe of her midwifery education which corresponds with the years when she continued to work as an obstetrical nurse and also gave birth to her two children. Here, identity stories linking the maternity care she received in her two pregnancies to how she views herself and conducts her care are prominent. When we start to move some of our conversations into print and she reflects on my early writings, she writes to me with her reactions: *My first thought is that my practice has a lot to do about me. Even though I talk about autonomy for the birthing person, it might be about what I want to offer. Maybe I'm not as altruistic as I believe. Perhaps what I offer is what I wish was offered to me.*

Kristen tells me about her births in reverse order. First I learn about her second birth, a precipitous vaginal birth after cesarean section (VBAC) in a hospital where she had nursed for several years. She had previously told me that when she tried to return to her nursing position following the birth of her second child, she was told by the manager that *too much had changed* and she was not welcome back. *And I learned afterwards, it's because they didn't like a way that I personally gave birth.* I learn that all Kristen's life, she had been looking forward to giving birth herself. She tells me that neither birth went as she would have liked which she feels probably *very much affects how* she cares *for others as both a nurse and a midwife.*

During our final conversation, I cautiously raise that she has thus far made no mention of her first pregnancy. Kristen chuckles with surprise as some overlooked but key memories come back to her. She has now consciously identified that the characteristics of the care she received during her own births were the impetus for her resolve for autonomous practice and a strong orientation toward upholding patient-choice. I tentatively ask about her first birth. *Well, that's a very big story.* Indeed.

I learn that Kristen had an unexpected and concerning bleed at 32 weeks of pregnancy while in the remote wilderness on a canoe trip. She had chosen to not have an ultrasound in pregnancy after reading a Dutch article in midwifery school that made a big impact on her making this decision that differs from the community standard of practice. *The title was sort of like "Spoiling the Pregnancy." And how when we go to check for one thing, like that baby is anatomically correct, we learn other things that ruin the pregnancy. And then we just fixate on that for the duration. How that can ruin our experience and how we perceive our experience. So I was very affected by that paper.* In response to the bleed, Kristen required a remote rescue in a fishing plane, multiple transfers to higher levels of care, then bedrest in hospital. Bored and fed up with the prescribed standard practice of bedrest which she doubted was efficacious, she wanted to leave. *I had to fight to get myself out of that hospital at 34 weeks.* She succeeded.

When Kristen bled again during a trip for a baby shower, she called the hospital where she had worked last a couple years prior. *I said, I have a bleeding previa and I'm coming in. And they probably thought, "What the heck is Kristen doing this time?!" And so I showed up. And the OBs—they were all known to me because I'd work with them for a while— and my baby was stable. He said, "Okay, we don't need to do the section right now because babe looks good," but he said, "Let me deliver the other two babies then I'll get you to the OR* (operating room)*, no problem." So babe was born at 35 weeks. She was good. But because my previa was more anterior, I had a postpartum hemorrhage and had to get packed. And it was terrible. And that I remember the next day the OB came to round on me, and I still had babe here [motions to her chest] and he said, "Have you put that baby down since she was born?" And I said, "No." And he said, "WILL you put her down?" And I said, "No, I will hold this baby for the next five weeks until she's term." Anyhow, that was always a joke. So that was my story. And then it was 18*

months later that I came back with the precipitous VBAC and wouldn't let anyone touch me. So probably that also flavors why they didn't want me to work there ever again. They probably think I'm totally insane [chuckles].

We return to her second birth that she had previously told me about with new realizations in sight. Earlier she had told me about the chief of obstetrics with whom she was required to meet in order to pursue a VBAC. *But he said,— and I was a nurse at his hospital and he'd known me for years, — He's like, "Kristen, do you know what we call women like you that want to have a VBAC? Specifically, a VBAC at home?" I said, "No, I don't." He's like, "DB." And I thought about it and I'm like, "I just don't know what that means." He's like, "Dumb broad." He's like, "Do you want to be a dumb broad that dies at home with her baby when you could have come here, and I could have given you a repeat cesarean?" And I'm like, [with sarcasm]* "*Thank you, sir." [chuckles] That's probably another reason I didn't get hired back there, because I refused to wear the name tag that said, "Dumb Broad."*

The misogyny in this account stings me; yet I sense within myself a distasteful combination of horror and resignation. I cannot conjure up a similar story, yet the quality of what Kristen tells me is somehow unsurprising and deeply known. I feel enormous admiration for her strength and defiance that I still have never been able to take hold of myself within the complexly coercive and, at times, abusive environments I've worked within as well. As a midwife now I should have the power to do differently than I could as a nurse, and yet, so rarely and so meekly I do. I feel trapped by an allegiance that truly honours no one, while Kristen has broken free. Or is it that she was never taken hold of to start?

The features surrounding Kristen's second birth present as a point of turning away from nursing and toward midwifery. Practically speaking, she was a senior midwifery student at this

time, yet I perceived from her stories that there was perhaps also an emotional shift that oriented her firmly toward the practice of midwifery and its tenets. I inquired with her if my interpretation was correct. She affirms this and talks about an awareness of something different within herself at that time but also a lack of language and capacity. I notice both a vulnerability and fierceness as she shares the impact of how she experiences watching the video taken of her second birth.

Kristen had taken a sedating antiemetic during her rapid labour and was cognitively affected by it at the time of birth. *And I remember watching it and thinking, like— thinking the words,—like, I could see myself: "Oh, you were thinking to say something, but you couldn't say it because you were still under the effects of Gravol."* Kristen becomes emotional recounting the memory. *I know I wanted to say, "DON'T take my baby!" And I'm still so mad. There was a midwifery student that came and she took him. He was perfectly fine. The apgars were nine and nine. He was pink, he was screaming, but because there was a pediatrician and the code team was there, she took him and brought him to the warmer. And he didn't need to be there. But I felt afterwards, I would like to track her down and find out if she has been able to become more empowered as a midwife. Because as a student, she thought they're all standing there waiting for this baby. So she took this perfectly well baby and brought him over when he didn't need to be taken away. [Crying] Both of my babies got taken away.* She goes on to describe her dedication to affording uninterrupted contact between her clients and their vigorous newborns even when someone from the resuscitation team is present and expecting to be given the baby for assessment. *I fight for my clients to have that skin-to-skin time.*

Memo Fragment #8: Completing Midwifery Education

Moved to Cuba then Mexico with her babies.

Always seeking the midwives wherever she went.

Ultimatum by midwifery education program to finish or get out.

Went back to practicum during maternity leave earlier than ideal in order to finish.

Moved north to smaller community.

Graduated from midwifery program in April 2011.

I'm both an RN and RM.

It is clear to me from the outset of our conversations that Kristen is passionate about international travel. When her second child was still an infant, the family moved to Cuba and then to Mexico. She tells me wherever she would go, she would always look for the midwives. *In Mexico, they said, "Why do you want to find the midwives? They are like the lowliest creatures here." And I said, "Well, those are my people."* She shares some of her knowledge with me about what she learned about maternity care and childbirth in Cuba and Mexico, and how the features reflect regional politics and histories, hierarchy, and medicalization of childbirth. She mentions the effects of colonization on diet and on health outcomes like gestational diabetes. I note her tendency to speak about pregnancy, birth, and care situationally rather than to favour a singular approach.

During her midwifery studies, Kristen followed an atypical program schema due to her advanced standing at admission. She took multiple breaks; eventually, *I got a pretty stern message from the director of the program: either come back or don't bother*. She does not share stories from coursework or practica aside from remarking that she moved to the small town where she grew up and completed her senior midwifery placement there, which sometimes involved caring for some old high school classmates. Kristen graduated as a registered midwife in 2011.

Memo Fragment #9: Working in Two Roles: RM and RN

Moves to smaller community.

Meets midwife Sarah.

Gets hired as a nurse there. "I'm a nurse and I'm a midwife and I want to work here."

Hired as an RM. Continues by working in both roles.

Teaching neonatal resuscitation program

The work of being a bridge.

Left obstetrical RN role for good. Chose midwifery.

After graduation, Kristen moved further north to the community where she still lives and works. She recounts the day her youngest child started kindergarten. *I dropped him off at school and I drove right to the hospital and I started crying in a stairwell. And a midwife came down the stairs and I recognized her from a conference, a midwifery conference. And I said, "Are you midwife Sarah?" She kind of looked at me oddly. She said, "Yeah." So I said, "Well, I'm a midwife too and I just don't know what to do." She said, "Well, you should just work HERE then."* There were no midwifery openings, so Kristen went to the nursing unit, *started chatting the nurses up and I said, "I'm a nurse and I'm a midwife and I want to work here." And so they hired me there and THAT was interesting in that they had assumptions about me that as a midwife, I was going to nurse in a certain way*. When a midwifery position in the community opened up, she obtained privileges while retaining her obstetrical nursing position. During some particularly busy years of parenting young children, she spanned both roles.

Kristen is an instructor of the neonatal resuscitation program (NRP) required of all of her perinatal colleagues. She remembers being approached by a respiratory therapist to start teaching NRP to multidisciplinary hospital staff. She tells me he said, *"Kristen, it would be so cool if you were a nurse but you're also midwife and then you taught this to everybody, and everybody saw that midwives can be cool also." Also!? I'm like, "Dave, do people not think that midwives are cool!?" [laughs]. He was like, "Well, some people have feelings about you. See if you can bridge it." And I said, "I'll try."* I relate to this privilege which can also feel like a burden to act as a bridge between perplexingly and senselessly opposing sides. Kristen emphasizes that the doctors did not like being taught the resuscitation program by a midwife.

She reflects on some of the challenges of working in two roles (i.e. obstetrical RN and RM) with two distinct yet overlapping scopes of practice on the same unit with the same

colleagues. Fearing she would be perceived as working outside of her nursing scope, she found herself calling the doctor in *probably sooner than they would have liked because I didn't want to accidentally catch a baby.* She describes an unintended consequence of this when a doctor she called "too soon" got frustrated and cut an episiotomy. *I blamed myself for that because she wouldn't have cut an episiotomy if the doctor had been able to finish her clinic before she came over, for example*. Additionally, Kristen recounts the interprofessional tension caused by moving between the two roles: *And it was VERY challenging for the obstetricians because some days I was consulting them and then some days they were giving me orders. And the nurses didn't like it that some days I was taking orders, and some days I was giving them orders or leaving orders with them.* I can relate to this social and interprofessional rigidity and do not know quite what to make of it.

Kristen also encountered confusion from colleagues during the period where she engaged both roles: *the OBs would just look at me and say, "Kristen, WHO are you today; are you a nurse or are you a midwife?" And I said, "If I am wearing scrubs, I am a nurse. If I'm wearing street clothes, I am a midwife."* I am struck by her pragmatic response to her colleagues that helped them to identify her set of responsibilities and scope of practice from one encounter to the next, yet wondered what shifts occur underneath changing her shell. When I inquire into this, Kristen talks about clothing and identity. *I think that part of your identity as a nurse wearing scrubs really reflects how you've integrated yourself into that institution. And you're following their rules by wearing their uniform. And conversely, when you're— I don't know what it's like when you've been a midwife, — but wearing street clothes is something that I have always done to kind of help people realize that we're normalizing birth, and birth can take place anywhere anytime. And you don't have to put on a uniform to do it. You're just a person that's in this role.*

She remarks on a negative phenomenon that I have also observed: *midwives don't get as much respect as other healthcare providers who work in the hospital*. She communicates her choice to don street clothes in hospital as an act of proud defiance: *Maybe that's also why I like to distinguish myself by what I'm wearing, because I want them to realize that I chose midwifery over nursing for a variety of reasons, but probably the autonomy that it affords is that primary reason. And I've been told before that I'm a person that doesn't like being told what to do. I don't argue that.* Kristen tells me that she is someone who likes to make her *own calls*. *I like to think that I afford the laboring person a lot of autonomy. And so I expect that in return in my own practice and in my own ability to be able to have that autonomy for how I provide that experience. Whereas I feel like if you're working as a nurse, then you're just following a protocol and the physician gets to sort of dictate the timeline*. Challenges notwithstanding, she suspects that being a nurse has afforded her greater respect from her physician and nursing colleagues compared with RMs who do not have a background in nursing.

Kristen looks back in awe at her life parenting her two young children and conducting the balancing act of obstetrical nursing and being a primary maternity care provider. Despite thinking that she must have *seemed like a tornado* to her family, she feels strongly about her boundaries around prioritizing her children above all else. Eventually, the challenges of maintaining both positions and negotiating the distinct roles forced a change. *It just became untenable I think to wear both hats. And so I realized that I would prefer to just be a midwife. And so I gave up the role working as a labour and delivery nurse and just carried on as a midwife at the same facility. But also maintained my nursing licence because I knew that I DID still want to be a nurse. I just wasn't sure in what capacity I wanted to do that*. Now Kristen has been working exclusively in midwifery for about 6 years which has reduced interprofessional

tensions. *Once I ceased being a nurse, everybody seemed more comfortable knowing very clearly which lane I was in.*

Memo Fragment #10: Life as a Midwife

Defending against negative beliefs.

Attending mock codes. Proving her skill as a midwife.

Attending parties. You used to be one of us.

Working in the Perinatal Mood Trial.

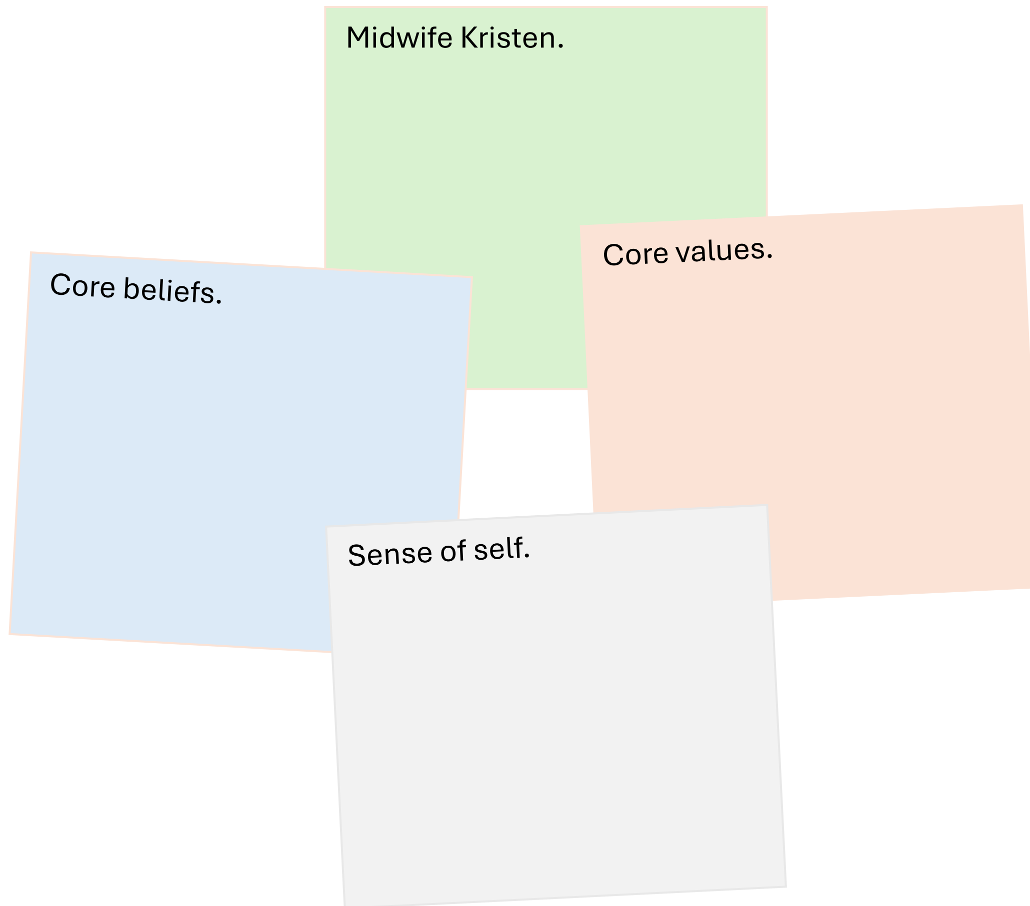
Cautiously embracing the flexibility and benefits of dual identity.

There is an unidentifiable moment along Kristen's timeline when she stopped being able to relate to obstetrical nursing any longer. Yet she continues to come up against her nurse identity through the ways in which others perceive and engage with her. I learn about the important work Kristen recently concluded with the world's largest perinatal mood trial. Though she was hired as a midwife into that work, she tells me that within that role she began to identify herself as a nurse through how she initialed her name with the designation as RN rather than RM. *I think that's because I had a sense that people perceive nurses as possibly being more skilled in that discipline. Because people have an underdeveloped, I think, appreciation for a skill set that a midwife can possess.* Maintaining her nursing licence allows her the title to help deliver this valuable form of perinatal psychotherapy. The addition of her degree in psychology renders her *unique* in her practice.

I wondered if any nurses she works with remember her as a colleague nurse. *I think they do when there is a social event. And I'm like the only midwife that shows up and then they remember, "Oh yeah, because you used to be one of us. That's why it makes sense that you're here, because you used to be one of us. And now you're one of them." There is a bit of a divide for sure. Yeah, there's an us-them culture, unfortunately. So I sort of can still go back and forth, but I've been a midwife longer than I've been a nurse there now so I think it's hard for people to see me as a nurse.* Then she tells me about being in the operating room with a birthing client the other day and it was time for the urinary catheter to be inserted. She tells me a nurse commented "*Kristen gets it, she used to be a nurse."; "Kristen can do that. She used to be a nurse. She's one of us still."* She continues, *so people talk about me like that a little bit there. Yeah, so (...) It makes me feel a little bit revered. But it also helps me to notice that people, a lot of people, value my nursing knowledge much more than my midwifery knowledge. A lot of people still think*

midwives are complete flakes. She describes one way in which she actively protests this false belief in defense of midwives by attending mock codes for neonatal resuscitation beside her physician and respiratory therapist colleagues. *I think I've very clearly shown my skill set there. And I always make sure that I introduce myself as a midwife at all of those.*

Memo Fragment #11: Knowing Midwife Kristen



By now, Kristen has worked exclusively as an RM for five or six years though she retains her nursing licence thanks to the overlap in competencies: *Every year I renew and it asks you "Where are you working? And in this location are you practicing nursing in some capacity?" And I always say, "Well, yes, I am, because I'm doing the EXACT same thing that I was doing as a nurse, except now I'm catching the baby also. I'm starting the IV, I'm admitting them to the hospital, I'm doing all the monitoring of the labour."* Now Kristen dreams of doing midwifery work (or perhaps nursing, she wonders) in a remote northern community.

Once Kristen starts offering language around her own identity. I no longer need to read between lines to search for her. She shares stories underscoring core beliefs and values that are consistent over time. I hear that she is, and always has been, *just trying to preserve that person's birth experience which didn't seem a priority for other care providers.* I hear, *when people are with me, they know that I'm going to respect them and accommodate them so they usually come back to me*. She illustrates her *hands-off, low-intervention style* from her early obstetrical nursing years through to now. She tells me that she is a *relaxed*, *easy-going*, *pretty liberal midwife*. When accused of being a "pushover" by a colleague recently, she countered, *no, I'm not a pushover. I respect autonomy and informed choice. And if a woman is informed and this is what she's choosing, I have no objection to that.* Kristen elaborates, *I think it's because I actually hear what people want and I will accommodate those wishes if I can help that happen safely. And that's why people actually ask for me*.

Kristen recently made a shift to a team-based model where she provides care as primary midwife in pregnancy and after birth but takes turns with colleagues being on call for labour. Social media posts in response to the announcement of transitioning to teams brought her more clarity both on how others view her and what she values most in herself. *And then I realized,*

wow, people said a lot of nice things about me being at their birth. But I think the most remarkable thing that someone said was that "Kristen protected my birth." That "Kristen protected me." Kristen becomes emotional with this memory. *I can't remember who it was or what happened. And I realized, yeah, because sometimes we do have to protect people from obstetrical violence. I'm not sure why that makes me so upset, but I think it probably always does come back to my births. And that I really want people to get what they wanted, and what they want. I know it's just one day in their lives and the antepartum and postpartum care means a lot also. But I think being a guardian of normal childbirth is probably what the most important aspect of midwifery care is for me. And that's why I go out of my way.*

I hold deep gratitude for all that Kristen has generously shared with me of her personal journey to becoming a protector of birthing people and guardian of normal childbirth in her roles as maternity nurse and midwife. She has offered many reflections that have raised new wonderings for me and sparked new ways of thinking. I have learned so much from her. I know that Kristen's stories of professional identity will continue to unfold in her life well beyond the close of our research relationship.

Chapter 5: Narrative Account for Joan

From the day I met Joan, I was taken by her vivid storytelling. Her detailed recollection of her journey from nursing then midwifery—with far afield travels along the way—served to illustrate inspirations and personal transformations. As I listened, I felt drawn into her adventures, moving with her through time. Immediately, I imagined that her narrative account could be presented as a travelogue written largely in present tense to reflect the liveliness of her descriptions. This format offers an organized yet creative space for the vibrant stories she shared.

After an introductory discussion, our three 60–90-minute conversations were by videocall during the winter. We were both in our homes, usually in front of the heat of a wood burning stove. They felt cozy. As our relationship developed, Joan began to grapple with sensitive topics related to navigating dual professional identities and their distinct cultures and assumptions. To reflect this, as the travelogue progresses through Joan's timeline, we arrive together at present day when she shares thoughtfully on topics including interprofessional tensions, informed choice, and childbirth fear.

I am struck by Joan's warmth and positivity as she recounted stories of the people and places that feature in her stories of education and work. I connect with her desire to see the good in others and to avoid harmful generalisations. Recurrently she illustrated her commitment to fostering positive relationships across disciplines by emphasizing strengths over shortcomings. Joan helped me to develop an acute sensitivity to her dedication to fairness and diplomacy—two qualities I strive to reflect respectfully throughout this narrative account.

Narrative inquiry calls on researchers to be self-reflexive co-travelers with participants. Joan shared her experiences generously, and I often found myself relating to the joys and privileges she described in her perinatal nursing and midwifery work. I also recognized the

challenges and complexity of living within and seeing into two overlapping though distinct professional worlds that are sometimes in tension. I am mindful of the risk of projecting my experiences onto Joan's in ways that might distort her intended meanings. At the same time, I trust her capacity and authority to guide edits that ensure her truths remain her own.

The Early 2000s: High School and Home Life

Joan takes me first to the Canadian countryside where I visit her life as a teenager when her early interest in maternity care first sparks. She lives in her family home, keeping horses, and at times attending rodeos. She describes her mom's amusement with the state of her bedroom, *which would be always very neat and tidy, and everywhere everything had its place*[5], a noteworthy contrast to the rest of the family home. She tells me she had been enrolled in air cadets when she was *really young* where she was immersed in a culture of discipline. Joan's aptitude for order and taking initiative had previously prompted her mom to volunteer Joan for two full summers' worth of childcare of a 1- and 3-year-old. *I really loved the connection that I had with the kids.*

At 14 years old, Joan is in a class at school researching different careers when her friend, who lives on a cow farm near Joan's home, stumbles on a job *where you get to take care of babies all day*. Joan tells me, *I loved babies from a really young age,* and this career sounded amazing. Rereading her transcript, sweet memories enter my own mind of me as a pre-teen at playgrounds and swimming pools always searching for babies to take off their parents' hands for a little play.

Joan works part-time throughout her high school years and talks often to others about her dream of working in the Neonatal Intensive Care Unit (NICU). She forms a connection with a couple who are regular patrons of the rural restaurant-bar she works at. They are expecting their first child, and they invite Joan to their upcoming birth. *So yeah, they called me and I went to her birth!* Joan describes meeting the couple for a labour assessment at the hospital. *In the middle of*

[5] Note: All *italicized statements* are direct quotations of the participant. Words in italicized *ALL CAPS* are those that were emphasized by the participant within a statement.

the night—I want to say I was 16 or 17—and she went [to the hospital] and she was early. The couple is sent home to await active labour. *And we were going in the elevator and we thought we'd go get lunch somewhere in [town]. And a woman in the elevator was like, "Oh you're not ready yet?* Joan drops to a low, sly tone. *She said, "Drink a shot of castor oil."* I laugh heartedly finding this unsolicited lay advice comically uncalled for and entirely familiar. Strangers can be so free with their prescriptions for pregnant women. *And so she did; we went and got castor oil.* Joan smiles. *That was my first introduction to castor oil.*

Immediately a childhood memory of my own introduction to castor oil pops into my head: the infamous story of how my father was born. Due in July and fearful that her physician would leave on his holidays before she gave birth, on her own initiative my grandmother—the pragmatic nurse—took castor oil. It was her first baby and she launched into precipitous labour. This story was recounted to me several times over my life (though rarely by her) that she birthed my dad all alone at home on her bed while her husband ran to the neighbour's to borrow a car to take her to the hospital. Joan continues, *And so she did, she took that, and then we were back in the hospital. I think she ended up having a really fast birth. And I ended up at one point on the floor in the bathroom almost fainting because it was just TOO much. It was…—I was…—yeah…— At that point, I just felt, "Ugghh" [grimaces]. And then I thought, "I don't think birth is for me." At that time. But I really liked the baby part.* She recounts the rural *neat little connections* she maintained with the family, acquainting me with how much she values relationships.

Joan self-identifies as a *planner* and *organizer* from a young age. Determined now to become a NICU nurse, she carefully chooses her courses and maintains honour roll status to increase her success. I delight in her story about shadow shifts she did during a high school

careers placement where she buddied with a nurse in a level 2 NICU: *I was basically cuddling and helping change babies and stuff like that. And I LOVED it!* Her experiences on this ward fuel her confidence in her path toward NICU nursing: *I'm in the right field, I'm going to do this thing*. We laugh over an ultimately harmless mishap where Joan was instructed to give a dose of Vitamin D and obliged enthusiastically: the nurse said to me, *"Can you give it to the baby—it's due for vitamin D", and I said, "Ya, no problem!" And then she found out I was a high school student—I wasn't a nursing student. She was this older nurse, she was so sweet but—I just saw the blood drain from her face— [laughs] she said, "You can't, you can't be giving any medication."* As I write this, I wonder whether non-nurses would detect the layers of scandal and humour in this story. Perhaps it requires a lived experience to grasp the implicit and explicit rights, wrongs, and rules within nursing. Next, I try to conjure a similar scenario from midwifery and am unsuccessful. It doesn't land the same way at all. I should ask Joan her thoughts on this.

Staff are encouraging of Joan's career dreams and she is invited to another birth. *I went to the staff lounge and I told them, "I can't believe it—the woman pushed in all these different positions! She was on her hands and knees! She was on her side [...]!" And all the nurses rolled their eyes, and they're like, "MIDWIFE birth." [laughs] And I didn't even know then that I was at a midwife birth. I had just gotten invited to go see this birth and I don't remember the midwife or anything like that. I just remember being in awe because that other birth that I saw was very different—the castor oil birth. She just had to be on her back and it was very much—it felt like THEY were controlling the situation—the nurses and the doctor. Versus the midwife one felt like the woman, SHE was the one who could say, "I'm gonna..." You know, it felt more empowering for her.* Joan describes having *tucked those thoughts away* until a woman's studies course in university.

Joan describes hiccups related to changing from the university to college stream of high school education to align her workload with that of her then boyfriend, only to learn two years in that nursing is imminently transitioning to a university degree program. She is set back one year. *I'm pretty determined when I want to do something,* so she does more research about paths that would ultimately allow her to take the NICU speciality training. She leaves college and begins pre-health sciences courses with enough scholarship funding to manage the financial burden.

Nursing School

I move alongside Joan now through the five years of her nursing education. She becomes close with two nursing classmates who are sisters with young children. Joan is in the *guinea pig year* wherein the newly established degree program focuses heavily on academics which includes writing many papers. At every opportunity, she chooses to focus on women and children. When asked in a women's studies class to select a theme about *a disconnect in healthcare where the research says one thing but practice isn't keeping up*, she elects to write about skin-to-skin contact between mother and newborn. Next, she writes a paper about the medicalization of childbirth. Her orientation toward these topics plants a seed for redrafting her dream career. *This women studies class kind of made me see the other side.* The professor asked to speak with Joan directly: *she called me into her office—and I really looked up to this woman—And she's just like, "You're not in the right field." And can you imagine!? Because up to this point it was a dream that I had from grade nine at 14 and now I'm 21, so six or seven years that I've been working towards this dream—and she told me, "This isn't going to be for you."* I watch Joan chuckle at the irony, retaining her good nature. *And I—I was upset but she said, "You should look into midwifery*."

I am struck by the boldness of the women's studies professor—how can she just say, *"This isn't going to be for you*"? I feel a familiar defensiveness rise in me. It is a feeling with which I am in frequent conflict. I want us all to believe that the nurse stands firmly on the right side of wrong—nurses do good work, they are good people, they and their efforts are enough. I want that to be the objective truth. As usual, I feel deeply protective, yet it is unjustified, and I know it. Herein my conflict lies.

I wonder what the professor knows about NICU and midwifery, questioning privately if her beliefs were formed from books or life, or both. I ask Joan. *I think she had children and I think she chose midwives*. Joan reflects on the situational qualities that prompted her to take note of the professor's comments: *It's just one of those things in university where you feel so inspired; I looked up to her so much. And it was interesting because I was going through the breakup of the really kind of horrible relationship that I had had for eight years. So during that time, I just put all my energy into working on these papers and stuff like that, and researching different areas that I was interested in. So yeah, it's just…it was a transformative time.*

After a summer spent in western Canada tenting on her sister's lawn and painting houses, Joan returns home to complete her senior nursing placement. She laughs as she enjoys the memory from that summer of having called an old high school friend who had moved to the area. She invited him to go camping. (I was touched to learn they are now married; so much of Joan's next adventures are tied to his own path as they begin to form their life together.) Now a fourth-year nursing student, she is back in the hospital where she had completed her high school NICU shadow shifts and observed her first births. Preparing for the transition to registered nursing practice, Joan is learning on several units: labour and delivery, postpartum, pediatrics, and NICU.

I floated all over the place and did full-time for four months. With nursing graduation on the horizon, Joan makes plans to return to the west to be near her future husband.

First Job as a Registered Nurse

After nursing graduation, Joan maintains her determination for NICU specialization. *I moved to [the city] and I didn't want to do med-surg* [i.e. medical-surgical nursing]. *Everyone says, "Do your nursing and get into med-surg."* I tell her that I also did not. *Ya, I was never interested in that kind of nursing.* Me neither. Though there have been times I wish I had forced myself to do medical-surgical nursing for a couple of years first. It could have helped when I had to give a simple nebulizer on the antepartum unit ten years after nursing graduation and had no idea how to do it. I felt so embarrassed and inadequate. In moments like that, I feel I am not a "real" nurse.

Joan shares a relatable objective: *I specifically from the beginning always wanted to work with women and babies. So, I wrote a letter to the manager of the [hospital] NICU unit. She invited me in for an interview.* Joan recounts the interview process. *It's crazy; there were SO many questions that I did not understand at all. "Do you know how to change a UVC line dressing? Do you know…?" all these really advanced nursing skills*. The manager was gracious throughout expressing to Joan that she understood that she would not have had experience with those skills yet, *not a big deal.* She tells me, the manager *was way more interested in my passion to work in the NICU and I told her right from the beginning. And I brought a portfolio and told her how I did placements from high school and whatever. And she hired me as the first new grad hire at [this hospital] in the NICU.* I am impressed. She laughs. *Yeah! They had never done it before.* I interpret that these events align well with Joan's spirit of adventure and conviction in her goals.

Her tale reminds me of being a new hire into the first cohort of a pilot project for senior nursing students to work adjacent to obstetrical RNs in a labour support capacity. Optimistic and naïve, I did not recognize that they assigned us student staff to a careful selection of kind mother-hen type nurses who valued our potential. Joan's trailblazing in the NICU was not met by her new colleagues with the same open-armed welcome.

As Joan tells me about her experiences in this NICU, I feel repeated occasions of empathetic knowing. I start to appreciate the toughness of her character and her skillful, strategic optimism and hard work ethic to deal with the challenges of nursing culture. She introduces me to her new colleagues—primarily senior, *really experienced nurses* with high standards who were committed and competent. *I got put in the step-down part of the NICU with the feeders and growers—the transitional babies, not super sick.* While I can immediately conjure a sort of known image of her next descriptions, I cannot locate any conscious memory of the same. *So I got put in there with basically nurses who were going to retire, who hadn't worked with new nurses ever. I got eaten alive. [laughs] Not in a horrible way, I mean, I have a pretty thick skin.*

I rewatch the video transcripts of this discussion several times to try to make sense of the mismatch between words, tone, body language, and reality. I note she speaks with a radiant smile and palpable warmth. I learn that Joan's mentor nurse was *excellent* and *protective*. *She really informed a lot of my practice*. Meanwhile, Joan describes challenges. *But they would just overload me. I remember one day I admitted five babies, I think.* She proceeds with a willing, upbeat tone: *I was like, "Sure! Sure, whatever." And I would do all the work or whatever but looking back, they really took advantage of me. And that's fine. [shrugs and smiles] And then it's funny because they were kind of nasty.* She corrects herself. *Not nasty, but they were kind of*

like… they would throw…, they would overload me with work and if I missed something, they would report it.

I am still sitting with her previous words, "*and that's fine*" as she gives me more details. I can feel a bit of unease in the pit of my stomach. I hear her acceptance. She clarifies, *I was eaten alive but I was very fortunate to be there and have that wisdom and knowledge passed down*. And while their treatment, especially at the start, was trying at times, Joan talks about nurses' support of her: *I was loved there too*. I see Joan as a new nurse who simply holds her head high and works harder; I believe I would do the same.

Joan offers me a story of being in an overworked situation wherein staff believed she had not acted diligently. *One time there was a baby, and I changed shifts. And it was a really big baby and it was tachypneic. And its temp was a little high. So, I think I took a layer off or something. But then I got reported for not calling the doctor, but it was change of shift when I admitted the baby. And they reported me because I didn't call the doctor about a temp of 37.7 C. And the oncoming nurse was like, "This baby is septic!" and they did cultures and everything. And it was though I missed it.* (It turns out the baby was well.) Joan describes the nurse who she thinks reported her by using words such as *really loud, outspoken,* and *strong personality*. Also, s*he was lovely. I really liked her*. I watch how Joan holds it all true; she seems to manage the injustices by detecting shades of grey, humanizing those involved, and choosing to see the good.

Joan further restores the balance in this tense situation by explaining that the person responsible for dealing with the report was supportive and understanding: *the unit educator looked at what I had that day and said, "You admitted FIVE babies. And that one came right at shift change." Looking back, they overloaded me and then if I made a mistake, they were like (…).* She doesn't finish her sentence; I sense that she does not want to belabour her colleagues'

unfair behaviour. *But then it's so funny: nurses eat the young, which is fine—whatever.* There is that sentiment again. Acceptance or resignation? Maybe survival. *But then as soon as they graduated me to the next level of NICU, with the really sick babies with cardiac issues, ex-26 weekers, all that, then they were SUPER protective of me and they're like, "She's ours!" And they had all this respect because I made it to the next level. And… I don't know… [shakes head and smiles].* I don't know either. These complex layers of nursing culture, socialization, identity, power—I find them hard to understand.

To the North

First Community

After about a year of work and many positive memories, Joan and her boyfriend embark on a shared adventure. *I had always wanted to live in a cabin in [the American north].* Now the timing is right for them both. I follow them on a road trip to the first community, *this really cute town. It's an artist community. There's a spit that goes out into the ocean for kilometers long; across there are white capped mountains and glaciers.* They lived in *a tiny old cabin. It was an old wooden shipping container from a boat that a woman made into a cabin. And we had an outhouse.* Living off savings, she investigates local work options. Although she applied there, the NICU in the city was four hours away. *So then I just went into the local hospital and I went and spoke to nurse midwives.* She details the political backdrop of midwifery in the United States with its different tiers of midwives and the animosity between them. There was no opportunity within maternal-child care for her in the community she was living, so Joan accepts a nursing position in long-term care.

Joan enjoys her work in long-term care as she has always loved caring for elderly people, yet she starts to *really miss the baby side of things.* She recounts that she used her

knowledge gained in the NICU to help a doctor struggling to keep a poorly growing premature newborn in the community. Drawing from order sets and care plans she had implemented many times previously, Joan's intervention allows the baby to stay in town. This saves the parents thousands of dollars and a transfer to a higher level of care. The doctor gives her a beautiful pendant to thank her. I feel the impact of this experience when Joan tells me she later cried in the supply room over how much she misses babies. I am curious how she feels about the opportunity to have her expertise consulted and valued. Based on her previous stories, this may be new.

To the City

More adventure transpires with a turn of events: Joan gets a call from the city NICU about her resume and receives an interview offer. But the logistics are not simple. They negotiate with Joan to *come and work a bunch of shifts and then go back to [home]*. She tells me she had *a really good interview*. Then they ask her where she would stay. *And I said, oh, I can live in my van! [laughs] And everyone laughed. They thought it was hilarious. But that's what I ended up doing.* It turns out that there is RV parking behind the hospital. For her stretch of six 12-hour NICU shifts, she works, sleeps, uses the hospital gym and shower, and then returns to the town to be with her boyfriend.

I find Joan's descriptions of this NICU quite mesmerizing. She is now working in an innovative unit designed to be a womb-like environment with careful sound surveillance and indirect lighting. *They had just thought of a LOT of things*. *It was a beautiful NICU. And again there I made friends with a nurse who was just like, "You should get out of this environment and work as a midwife. I think you would love midwifery."* She told Joan, *"Midwifery is such a nice career because you can follow people all the way through."* Joan offers this as the second example of someone directly encouraging her toward midwifery but I am curious what she thinks

at this time. What does she now believe about midwives and what does she know about Canadian midwifery?

Now the time on her temporary visa has lapsed and Joan is required to take the American registered nurse licensing exam— the NCLEX. She is now 22 years old and has a relaxed approach to the exam. She feels somewhat ambivalent about whether to stay in that city or follow her boyfriend who is seeking new work in Canada. *I didn't study for the NCLEX and I failed it. I just went in so cocky; I thought, "I've never failed an exam."* It was a lesson. *I took it really hard. It was an ego hit, but at the same time I should have prepared*. She tells me about the heavy and difficult pharmacology sections that were focused on medications she hadn't used in the NICU or even learned about in her Canadian nursing education. *Anyway, it was fine. It wasn't meant to be.* Out of work due to a lack of nursing registration, the next day Joan packs her bags and leaves the USA.

To the Canadian North

The next leg of Joan's journey transpires in the Canadian north. The north is somewhere she has always wanted to work and she is not ready to leave. Practically, the higher wages also help her pay down her nursing debt. Upon leaving [our home], *I drove across Canada. It's 18 hours just from [that American city] to White Horse to give you an idea. It's a REALLY far drive.* She describes driving alone in her poorly heated Volkswagen van trying to withstand the cold by wearing a snowsuit. Promptly she hears from a northern Canadian hospital with an interview offer in maternity care. It goes very well despite being asked many labour and delivery questions to which she had few correct answers due to lack of experience. The manager is eager to hire Joan because of her NICU knowledge and skillset that few current staff possess. She is hired with reassurance that she will be trained for labour and delivery.

I relish Joan's imagery-rich storytelling that draws me into her life in the Canadian north. For two years, she and her boyfriend live in the old area of the city in *a small little apartment. The lake freezes over, and we lived across an airport where the planes would land. They would light barrels on fire and that would be the landing strip for float planes in the winter.* They bought their *first dog*, and a *little truck* to get around. She shows me a couple of photos including a heartwarming one of her and her boyfriend dancing *in an ice castle in the winter*. *It's an ice sculpture with art all in it and then live music comes.* She describes her time in that community as *a beautiful experience,* emphasizing its uniqueness and speaking with tenderness. *I loved working in the north.*

There I got trained in postpartum, labour and delivery, and then NICU. The NICU capacity is very different from what she knew elsewhere. *If they couldn't transfer out because of weather, sometimes they would say, "Okay we're gonna try to keep this baby locally. Can we staff the NICU?" And that was a huge part is that I would come in. And then, over time, there was another nurse hired with NICU experience as well.* I discover that here Joan learns to resuscitate babies and commonly initiates positive pressure ventilation to neonates with respiratory depression at birth. *I didn't get that experience in the bigger NICU because that was for experienced nurses—the resus team.* She works with an obstetrician who is very pro-midwifery though she does not recognize that at the time. *He was very pro vaginal breach births so I would go to vaginal breach births not knowing very naively that this is NOT being practiced everywhere.* This unit is comprised of a *really good team* of young eager nurses with a complement of experienced senior nurses. There aren't a lot of *politics*. Joan is often made charge nurse. I sense a maturing within her career in terms of confidence and skill during this time.

Turning Toward Midwifery School Applications

Joan's two years in community contribute to a turn toward midwifery. *I think after a couple of years I felt, "Okay, now I think I'm ready." And I started researching going back to school for midwifery. I had it all in my head and was completely set out—I contacted Napier University in Scotland. So, I decided, "I'm going to go to Scotland next and bridge over there."* But she changes her mind to avoid a student debt in pounds. Joan learns from a nursing student that, to her surprise, she can become a midwife within a Canadian institution. I wonder to myself, aside from cost, what more did you know about midwifery education and practice in Scotland, Canada, or elsewhere?

Joan's story has me recall how I formed my own plan to become a midwife. I had become disenchanted with the culture of the obstetrical units where I nursed. I was restless in my personal relationship. I was ready for another trip abroad. I scoured the internet for midwifery programs for nurses, selected a small handful, then for reasons I can't remember, set my heart on a program in Wollongong, Australia. I knew nothing about variations in midwifery education, philosophy, or model of practice between different areas of the world. I had no idea where Wollongong was. But it sounded exciting which was enough for me, so I applied.

Beliefs and Assumptions About Midwifery

I detect that Joan has gone against the grain by turning toward midwifery. She reflects, m*idwifery is the anarchist sometimes of the traditional medical system and how we put people through it.* She recognizes that the midwives commonly call out what *isn't right and that bugs people*. Aside from the women's studies professor and one NICU nurse in the north, *my experience with midwifery from the nursing perspective [...] was pretty negative to be honest*

from the nurses. Tactfully, she searches for words. *It was never a positive… they didn't regard the midwives… it wasn't collegial. It was kind of like, THEM.*

She tells me a story with familiar themes of staff othering midwives, judging them harshly, and doubting their competence. Reflecting back to her first year of nursing, she tells me, o*ne of the head nurses in the NICU pulled me once to a baby who was really sick with hypoxic ischemic encephalopathy—so HIE—and she said, "This is what homebirth does."* Given that homebirth is only offered by midwives, I sense that staff chatter about poor homebirth outcomes (which are always seen in hospital due to their need for extra care) are treated as surrogates for informally evaluating midwives' worth. Joan had never talked about midwifery to these colleagues in the NICU, yet this nurse told her, "*NICU nurses do not like midwives."* Joan is somewhat perplexed by this based on her limited direct experience with people from this profession: *I remember the midwives coming to visit, which was not that common, but say if the baby had TTN* [i.e. transient tachypnea of the newborn]*—because that's the side of the nursery I worked at—I remember them coming to visit. They were so nice and collegial.*

South American Trip

After finishing her nursing contract and saving money, the couple decides to follow another dream of backpacking in South America. *Just before I left, I applied to [a Canadian university] to the midwifery program.* Joan conveys how unattached she was to her plan: *I was like, "Yep, if I get in no big deal and if not, I'll find a nursing job."* That roll-with-it attitude is a dearly familiar yet distant memory to me now—maybe to both of us as we juggle motherhood, careers, and our households. *You know, you're young, it's like—whatever—we'll go and work somewhere else.* They stayed 4 months, traveling and volunteering at organic farms. *And while I was in Chile at one of the hostels, I got an email saying that they accepted me to the interview.*

Entering Midwifery Education

Back in her hometown, she commits to interview preparation. To support the application process, *I read all I could about the College of Midwives in [my province], their core values, their beliefs and everything like that—and I found it fascinating.* As she researches, she starts thinking about the Canadian midwifery tenet of informed choice and its application to her nursing work. *I was kind of already practicing some of the caveats of that as a nurse…but some not.* Joan becomes more serious and I wonder, do I detect tension in this truth-telling? Maybe a conflict between liberation and betrayal. As good nurses, are we allowed to call out the trespasses? Or maybe I am reading myself into things. *And I really learned a lot going through midwifery. It was kind of an eye opener to how some things are just not right the way I was trained as a nurse.* She retains her smile. Joan does well in the midwifery program interviews, crediting her nursing experience for much of her strong performance.

Next, she is offered a second interview. It is for the shortened program designed for applicants with a healthcare background. *I did this other interview where they were very much questioning what my motive was as a NURSE to become a midwife.* All five applicants are also nurses and all are accepted. Looking back, I recall that, like Joan, I also had fun with my interviews and felt confident in my efforts. I was perhaps lucky, however, that no one pressed me on my stance as a nurse transitioning to midwifery. Without a doubt, I wanted to become a midwife who was ALSO a nurse, still doing and being without question—*Nurse*. I am not sure how that explicit declaration would have been received by the admissions panel. Listening to Joan, I am curious what she imagined her turn toward midwifery would mean for her nurse identity? I wonder if she considered what she would retain of her practice or what she would have to walk away from.

Studying Midwifery

Joan brings me through her grueling though immensely fascinating midwifery education program. Balancing six courses in one semester and commuting, the demands of the program affect her health. *It was so incredibly stressful.* Once she reaches clinical placements, she thrives. *I did really well in clinical skill. I was teaching the other midwifery students how to do IVs and stuff.* I share her experience. In fact, the program I took offered me to be a clinical skills assistant for my peers. We worked in basic classrooms, setting up on desks to learn the skills as a group. I remember pressing program leadership on why we didn't "just learn these skills with the nursing students." The reply was vague, but clearly a "no." I imagined nearby departments housed well-equipped clinical skill labs led by seasoned instructors who made learning procedures like catheterization and phlebotomy both systematic and memorable.

There were layers of history, politics, and inequity underlying midwifery's establishment as a primary care profession and a university program that I did not (and still do not) fully grasp. Now, after a decade of teaching to midwifery students the clinical skills that are routinely also performed by registered nurses, I find myself curious about the value and losses of intra- versus cross-disciplinary instruction. I wonder what nurse Joan emphasizes when she teaches clinical skills for her midwifery student peers. How might her approach compare to that of a practising midwife? What assumptions, priorities, knowledge base and values do practitioners of these two professions bring to overlapping clinical skills like medication administration, aseptic technique, and newborn exam? What, if anything, changes once the practitioner becomes a dual registrant?

During her program, Joan is connected to six different midwifery cohorts across two locations. One site is comprised mostly of creative, mature students, and the other has mostly younger, academically high achieving students. She expresses her affection and appreciation for

both groups and the diversity of students' styles and beliefs—*you need all kinds of minds in the world*. Joan identifies more strongly with the *open-mindedness* and *inquisitiveness* of the more mature group who tends to avoid black and white thinking. She emphasizes the importance of recognizing that patients have their own experiences and deserve to be treated as individuals free from staff preconceived notions. This value appears to be strengthening during this time. The *creative style* to which she is attracted provides a welcome alternative to what she experiences in the medical culture. Finally able to focus on exclusively maternal child topics, she tells me, *I just LOVED the degree.*

Learning Informed Choice

One area of studying midwifery that gives Joan particular satisfaction is learning about informed choice. *I became very passionate about informed choice, and language.* Some clinical topics she learns to educate and counsel patients on draw her attention because of their level of controversy in literature or the variation in practitioner comfort. As an example, she tells me she became especially interested in planned home vaginal birth after cesarean section (VBAC). As she starts learning about this topic, Joan quickly learns to evaluate her choice of language against midwifery's philosophy of care. *I put up my hand in class and I asked, "Would you let a woman have a VBAC* [i.e. vaginal birth after cesarean section] *at home?"* I cringe—I feel like she has walked into a trap. I know what comes next. *One of the midwives replied," Well, it's their CHOICE. We're not "letting" them."*

In addition to becoming more aware of implicit assumptions connected to power, autonomy and decision-making, Joan is gaining research-informed knowledge to give her clients unbiased information. *My informed choice REALLY changed between nursing and midwifery because I feel like I gained knowledge where I could inform people more about the things that we*

do in labor and delivery where I didn't really have that honestly as a nurse. Actually, I did a little bit but not for everything. Access to the MoreOB obstetrical education program in the north gave her important information to help support patient education. She recognizes that MoreOB has a very medical lens. Some MoreOB information is included in midwifery informed choice but midwifery goes far beyond. *In midwifery I feel like they take stuff from that but then they go even further. They look at the history, they look at what we do globally, it's not just this black and white "This is what we do in Western Medicine and this is what makes sense." They look at it from a really broad lens I would say.*

She cites vitamin K for prevention of vitamin K deficiency bleeding in the newborn and erythromycin for ocular prophylaxis, two newborn procedures given routinely per standard of care throughout the time we were both nursing. As I listen to Joan's impressive knowledge of the history of mandatory erythromycin use embedded in post-war provincial public health law, I felt a wash of shame. Throughout my education, I struggled immensely with learning informed choice discussions to the degree expected of me from both a philosophy of care and regulatory perspective. Many of my moments of regret centre around my perpetual inability to conduct informed choice discussions sincerely, as though I could not align my comfort with the words I was expected to say.

During my third year of midwifery education, I was placed briefly at a high-volume urban clinic. My preceptor, an experienced midwife, asked me to provide an informed choice discussion about a routine newborn procedure. I had only met the parents a few hours earlier, and we were now in the operating room unexpectedly where their baby had been born by emergency cesarean section. I remember the pediatrician or nurse was standing in earshot—or perhaps I only imagined their presence. Either way, I felt the weight of an internalized pressure not to offer

“too much” choice—or any at all. I rushed through a version of what I’d learned as modeled in nursing, drawing nothing from my midwifery training: “It’s an ointment, applied gently to your baby’s eyes. It’s recommended to prevent infection. It just melts away. Are you ok if I go ahead and do that now?” My preceptor gave me a stony look. “I would have done that very differently,” she said. I don’t remember if we ever spoke about it afterward, but her dismayed tone stuck with me. I was carrying deep internal conflict and living it out in practice.

Joan gains a new perspective on the approach she had developed as a nurse to educating and gaining consent from patients: *I feel like my informed choice was so surface level*. I agree—as nurses we were not educated to understand the benefits, risks, and alternatives to many of the interventions we provided. I wonder if as a nurse Joan felt empowered to discuss interventions using a lens of choice rather than consent; I know I did not. In the student midwife scenario I described above, I now understand that promoting choice to families felt almost cruel to me. My experience had been that choosing against the standard of care could have negative consequences for families, unrelated to the intervention itself, that I felt unable to prepare them for. I worried about providers’ harsh judgement and even a change in care quality they would receive. I wanted to protect families from that. I wanted to help parents navigate the path of least resistance in a challenging environment, not set them up for conflict within it. Now I see how patronizing my attitude was.

Additionally, informed choice discussions about routine procedures, particularly against the backdrop of an unexpected turn in labour, often felt like an unnecessary, untherapeutic drain on parents’ limited reserves. Introducing yet another decision that they would need to shoulder, especially without helping them weigh its relative importance, felt wrong. Yet, who am I to know

what individual parents value or need? I made a lot of assumptions out of my own fears and projected them to the families.

In addition to surface-level informed choice, Joan reflects on delicate clinical exams she performed in her nursing role that she later learned in midwifery had not been done in a sensitive way. She felt that she had essentially been trained to *find that cervix! And don't come out of there until you can find that cervix!* I remember sitting among fellow new obstetrical nurses during a training session. The nurse educator was teaching us how to perform vaginal exams. "It is a privilege to have your fingers in someone's vagina!" she said. "A privilege! So don't come out of there until you have all the information your patient is entitled to." This was presented to us as progressive and respectful—the kind of quality care that patients deserve. And yet, between the directive, "Don't' come out of there," and the omitted fact that we nurses were not armed with information or agency to help patients decide for themselves whether we ought to go "in there" in the first place, I share Joan's unease with the memories.

Contending Pre-Legislation Ideals and Realities

As a student, Joan is fortunate to be mentored by midwives with a variety of educational and practice backgrounds. This includes a preceptor who worked as a Canadian lay midwife prior to midwifery legislation. I reflect on my own understandings of the realities faced by "pre-leg[islation] midwives" who were on call essentially all the time, paid in cash by their clients, and had to hide their care. In student placement, Joan encounters a scenario in which she forms views on a pre-legislation ideal of being "with woman" continuously. *I remember being up for 24 hours and then we got a page of another woman coming in. And the midwife asked, "Well, what are your thoughts?" And I said, "Well…"* Not strong in setting her own boundaries at this time, Joan tells me, *if I'm challenged, I'm going to go for it. I'll say, "I can do it" kind of thing.*

It's almost to a fault. Because then I said, "Well if she's fully, I'll stay. We'll stay on. But if she's not then we'll call for relief." I interpret from this that Joan expects that full dilation meant only a manageable degree of care will still be needed for this next client.

Joan has a relationship with this labouring woman from following her for months in clinic. Continuity of care is a core tenet of midwifery that she is working to integrate into her new identity. Joan is already aware of the pressures to stay "with woman" as she has recently been challenged over taking her allotted 4 days per month off call to attend a friend's wedding. Trying to help Joan set realistic expectations of becoming a registered midwife, her preceptor said, "*You're going to be missing events in this and that. Becoming a midwife, you're going to miss important moments with your kids*." Joan's pre-legislation preceptor did not have an expectation of a break when her clients needed her care.

There are layers of lessons in this evolving scenario. *And it was such a good learning lesson because she WAS fully.* As a nurse, so often I felt that the imminent birth of the baby was the end of the management; as a midwife, I've learned how essential it is to retain a reserve of energy and discernment for the most common birth complication: postpartum hemorrhage (PPH). *It was a primip. She came in fully. She pushed her baby out quickly. She had a massive PPH.* Learning comes from the tension in management between Joan and her preceptor. *I conservatively said, "Ok! We're gonna start an IV! and so on—like, my nursing mind.* She adds that up north, postpartum bleeding was managed very conservatively.

And the midwife was very tired and she said, "Well I don't think that's coming from the uterus." And I was almost getting into an argument with her. And I think I just decided, "No, I'm starting an IV." I feel like her judgment was off from being up for 24 hours and she was also an older woman, right? I hear compassion and concern in Joan's voice. It occurs to me that not only

is it unfair to the client to have been put in a situation where a care provider's judgement could be clouded by sleep deprivation; but it is not fair to the practitioner either. The outcome of this case was suboptimal and avoidable. *I went to bed crying and I thought, I don't want to work in a profession that pushes your physical and mental boundaries so far that you can't make decisions.* Joan initiates debriefing the events over tea with her preceptor and the two come to a shared understanding which she deeply appreciates. This experience solidifies Joan's boundaries around sleep relief though it competes with the purest interpretation of continuity of care.

Senior Year as a Student Midwife

I join Joan for her senior year midwifery placement with midwives who have privileges to a large urban hospital. *The midwives—they are awesome. Their homebirth rate is about 30%. I went to a good number of homebirths. They were a very well-oiled machine and they're very good midwives.* I would love to hear more about what impresses her about this group, what qualities she admires.

She tells me about her excellent preceptor who some of the other students follow when Joan has a day off—the preceptor *would put them to tears.* But Joan experienced her preceptor's mentorship differently and very positively. *I honestly feel that my nursing—that whole experience through nursing—it would just slide off. Like, it didn't… [shakes head and smiles] If she gave me critical feedback, I said, "Okay, yep!"* She embraces it as opportunities to grow and improve. *But I didn't mind swallowing up that pride and she was an excellent midwife.* Joan describes her preceptor as a valuable guide for learning informed choice discussions that she uses regularly in clinic—one of a Canadian midwife's primary practice environments, and a new place of care for her. S*he would pick them apart to make sure... I would do all the research*

behind them, and she'd say, "Ok, you're going TOO far in this area." She would listen to every word I said. Now I feel like I pass that on to the students I have.

As a student midwife, Joan is lower in the professional hierarchy than she has been in several years and finds that she is expert in only a fraction of what she is asked to know and do. *I definitely had to swallow up my pride of already having—I mean, I was CHARGE nurse in [the north]. You have to go down a level because you're a student again, right?* This has me recall misguided assumption spoken to me by some colleagues, family, and friends who felt that I, as an obstetrical nurse, was surely competent already with most of what a midwife knows and does. For longer than reasonable, I naively endorsed this false belief too. Even some preceptors at times believed more in my knowledge than was appropriate. I sometimes used this as a crutch until it occurred to me that I would be in trouble after graduation if I did not learn what was expected.

Joan, on the other hand, feels that while she is a well-rounded perinatal nurse, she recognizes that having had no previous homebirth, antenatal, or community-based care experience leaves her much to learn. She identified that the midwifery scope of knowledge and professional role have important differences that nursing had not adequately prepared her for. I believe I tried to resist that reality, myself, though I am not so sure why.

Upon Graduation from Midwifery

Joan graduates her midwifery education program with strong academic performance. She returns to the north to do a short obstetrical nursing contract to pay for her midwifery licensing fees. On the invitation of some of the doctors, she delivers a few babies. I ask about this transitional time—she is now a midwife but the first work she performs is back in her nursing role. Joan finds herself confronting the *preconceived notions about midwifery clients that I saw*

as a nurse but I feel were uneducated. Homebirth is a hangup for her obstetrical colleagues—*people could not believe that I had gone into midwifery and that I could possibly be going to homebirths*. *That was a line for a lot of the people that I worked with up there*. Joan assumes the role as an educator on this topic, explaining that homebirth with a registered midwife is well supported by research. She informs others on equipment and standards brought to planned homebirths, *excited to spread that information*. *I just gave them perspectives*.

This reminded me of being at the wedding of one of my closest childhood friends. I was approached during the reception by her aunt, a senior tertiary care NICU nurse, who caught wind that I had graduated as a midwife 6 months prior. She raked me over the coals. She was appalled by the choice of homebirth and scarred by the bad outcomes she saw in the NICU which she appeared to believe could have been avoided by birth in hospital. She did not appear to consider iatrogenic harms against some of their hospital-born patients.

Despite continuing to be close to the other care providers in the community, there was a shift wherein Joan now *felt in the middle, like I had to defend myself a little bit for the choices I had made*. She acknowledges the distance between the views of her nursing colleagues and the new views she had developed: *Before I was part of a team and we were all working together and I had held all the same beliefs as them. Then once I trained and went back I think I made some people uncomfortable because I was outside of that system now. And I was still so close with all of them—close friends with the unit manager and all the nurses, you know what I mean? But I think I made them a bit uncomfortable—I had some difficult conversations about homebirth and different things*. She argues over beer with a pediatrician at a pub. *Against the grain* is a new direction for Joan in this phase. She continues to prioritize connection in her relationships, tensions notwithstanding.

Life as a Registered Midwife

Joan and I have arrived together at the present day, where she is now working as a registered midwife. She brings her passion for midwifery education and advocacy into her first year of practice, traveling to surrounding areas to do community outreach and giving talks about midwifery care. She is hired into a practice in a new community. Her husband finds a great job and advances steadily in his career. Together, they find their dream home in the country and settle down to raise their family. She becomes a practice partner which adds business owner to her responsibilities. Thanks to a shared call schedule, Joan enjoys a sustainable work-life balance. I hear her gratitude for the *sacrifices* of the founders of modern Canadian midwifery. She believes midwives no longer need to universally subscribe to the restrictive solo-care work model that was once the norm.

Joan has collegial relationships with both her midwifery and hospital staff colleagues. *A lot of the older nurses—the baby boomers—are retiring and we're getting some really young, eager nurses*. She describes how the new nurses are using birth balls, encouraging women out of bed, and promoting upright positioning. *It's wonderful*. Her future dreams include returning to northern communities so her children can experience those special places, and perhaps living in another country. At times she considers if a perinatal leadership role could be in her future. She hesitates, questioning whether she would be *good for midwifery* given her level of empathy or perhaps allegiance to nursing. *I SEE the perspective from both sides maybe too much***.** Now in a place of relative stability in her professional and personal life after 10 years of local practice, we settle in to talk more philosophically about some aspects of midwifery and nursing identity.

Navigating Politics & Interprofessional Tensions with Obstetricians

Joan tells me about vacillating interprofessional tensions affected by staffing changes among obstetrical specialists at her hospital. Some of the old guard has retired and a few new specialist staff joined the department from a community historically hostile toward midwifery. This, combined with the change in midwifery scope that allows midwives to independently manage new aspects of low-risk care previously under the purview of obstetricians, has created uneasiness and division within the physician group that midwives commonly consult. *They brought that mistrust with them and we had had it good here between the OBs and the midwives.* This concerns Joan because she understands the fall-out from interprofessional strife goes well beyond staff. *From my point of view, I just keep it collegial because what we do know is that when there's tension there between even care providers in general—and I think this could go to any area the hospital—is that the biggest person who suffers is the patient or the client.* She reflects that her longevity within the perinatal team and the trust she is afforded by virtue of her nursing background have shielded her from a degree of the tension.

Backhanded Privilege

Joan reflects on the conflicted place she is put in by colleagues communicating a superior regard for her over other midwives because of her nursing background. *I have trust because I have nursing, right? There are remarks about that all the time which I feel bad because I love my midwifery colleagues and I think they're all excellent.* These praises sit poorly with Joan: *I have a lot of respect from the people I work with, but I feel that it's unfair. It's complimentary to me but it pisses me off because I feel like they're kind of disrespecting my profession. I feel like the midwives who don't have nursing should have that [respect] as well. And I feel like the things that [nurses] are going after them for are really petty sometimes.*

The Nurse Inside as Seen by Others- Systems, The Team, and Caring for Others

I asked Joan about what nurse is in her still. What does she think and do? How, if at all, is she recognized by others? Her mind immediately goes to her nursing colleagues on labour and delivery even though she has never been in a nursing role in the community she works as a midwife. *It's funny because you say how would you recognize her—THEY recognize her all the time. They say, "That's because you're a NURSE that you're doing this."* Joan does not accept that rationale unquestionably, wondering what degree her personality rather than professional socialization contributes to her style. I wonder what features nurses notice in Joan that they recognize as the nurse in her.

She goes on to describe that she is habitually attentive to process and the broader perinatal team. *Just the way things are done—I'm used to working in kind of a system and a team-like approach.* She tells me, *as a nurse you feel like you're really functioning as a piece of a bigger unit. And you help that whatever-it-is run smoothly. It's the team.* She offers an example that for which I feel great empathy: *So, it's a silly example but we put charts away where the charts go, and one of the nurses approached me in the staff room in front of everyone and she asked, "So Joan", quizzing me, she's like, "Where do you put your charts when you're done with them?" And I asked, "What do you mean?" And she said, "Well, where do you put them?"*

Joan's tone changes while she recounts this unfolding, conveying clearly that she knew she was being made an example of. *And I said, "I file them where they go."* She tells me the nurse replied judgementally: *Then she said, "Well, some of your COLLEAGUES…"* The nurse lamented in front of the group that the midwives put their paper charts they no longer needed *in the labs-to-be-filed bin instead of just filing them where they go*. *And it's such a silly thing but I wouldn't put that work on someone else, you know what I mean?* Yes, I do know what you mean.

Me neither. *It's miniscule but I know that our unit clerks are overrun. And I feel like that comes back for me working in [the north]* too *where I did do all my charts. There was a time in [the north] when we* [the nurses] *cleaned the rooms. You would do all the admission and admission labels. Working up north you do a lot of things that you would have someone else do in a bigger center. So it's a big contrast.*

As she continues this story, I detect that she is no longer just talking about habit or familiarity, but about systems-thinking and an underlying belief and integrity toward taking care of the bigger team. *At [that hospital] when I worked in the NICU, I would call if I ran out of three CC syringes and someone would magically appear and restock them. And then when I worked up in [the north], I feel like I was the stock queen at night making sure [everything was there] because I just hated going for things that weren't there because I'm always thinking of—well I try to always think of—that scenario of my colleague going for it and then it not being there. Because you have that scenario where you're like, "Okay, give the woman miso" and if you were to run and grab miso from the drawer but it wasn't stocked then you've got to go OUT of the room and go far away. It just would be really frustrating, right?* Joan deduces from *complaints* she receives *from the nurses* that she takes responsibility for these areas in ways that midwife colleagues may not. Joan recounts that the filing cabinet complaint ended as everyone in the room joined in to corroborate "*Well, SHE wouldn't do that. Joan wouldn't do that. She gets it—she's a nurse."*

Joan tells me about how she experiences her team approach in life and in work. She likes to play competitive sports and *was always on the relay team*. What a striking metaphor for the individual effort we make to pass off to a teammate to set them up for both their individual success and the success of the larger team. *I really am BIG on team approach and I like helping*

people out. And I think it's part of just being a nurse—you care for someone. You have that caring. I've always cared about others, and I have nursing that goes back in my family too. I could have spoken her next example myself. *So, if I was to take a warm blanket out of the warmer, I'm taking one out and I'm putting two back in and making sure it stocked. You know? It's that mentality that we work as a big unit.*

I wonder if initiating these well-intended team-focused behaviours have ever caused Joan challenges beyond the complex praise she gets from nurses. As a student, I recall being chastised by midwife preceptors for initiating tasks such as refilling the blanket warmer or restocking the supplies in my room. They'd underscore, "That is the nurses' job, Laura." I resisted them so insistently that at times my eyes filled with tears. Being blocked from helping gave me a sense of humiliation, though it seems odd to write. I'm still a nurse! I'm not too different—or what, too good?—to do this needed work. Meanwhile, my preceptors pushed back firmly with escalating tone. I wish we could have pressed paused, took a breath, and talked with gentle curiosity about what was going on under the surface for us both. Eventually, I began to understand that in my community, delineating midwifery work from nursing tasks was felt to be an essential phase of midwifery's work to establish itself in hostile environments where it still had inadequate perceived legitimacy. I'm not sure if my preceptors understood what was underneath for me.

I listen as Joan carefully forms her assessment of what feels simultaneously like *a negative dig to midwifery in some ways* and a grievance that has some legitimacy from the perspective of nurses. Based on nurses' complaints she fields about her midwife colleagues, Joan supposes that midwives graduating without nursing experience would not have fostered and integrated the sensitivity to this fundamental aspect of nursing mentality. *In midwifery you're*

such a solo practitioner in some ways. She shares that as a midwife, she has felt *a bit more alone.*

I sense a sort of sadness in my chest as she continues to grapple with the tension between knowing from within the two professions. I know these realities too. I've felt that these negative dynamics have existed for so long across many places in Canada that they seem eternal. Again, Joan offers the other side: *Then to fight from the side of midwifery—we do a lot as midwives. We work as the midwife at a birth and the nurse. We do documentation like the doctors do their documentation—we have to do that PLUS the nursing documentation. We're essentially working as two people in the role and THEY don't see THAT. So, I understand why. I understand it from both sides.* And given they get *brow beaten a little bit from the nurses*, she suspects midwives are not keen *to go out of their way to help [them]*.

For my student and first years of registered practice, I was also put in the position of sounding board (more aptly, dumping ground) for vocal doubts or complaints lodged toward midwives or midwifery, and sometimes from midwives against nurses or nursing. They often seemed petty as though ego was driving the gripe, though were sometimes more complex. I felt as though colleagues of both professions spoke more freely to me than they would to their peers of the same discipline as though they expected me to validate their concerns without appreciating the bind I was sometimes in. These tense social and political forces, combined with my yearning for team cohesion challenged my ability to integrate more wholeheartedly into midwifery. I really didn't want to pick a side. The pressure to do so sort of paralyzed me in some in-between place.

Joan shares more about the strain of being in the middle of conflict and admits that ignoring the *pull* toward midwifery and staying in nursing would have been more comfortable. *I*

never had anyone question me as a nurse about what I do. She tells me about the *constant* work of *defending* her midwifery profession despite regulation occurring over 30 years ago in her region. *I'm going from this really respected profession to one that—I wouldn't say it's not as respected but you are definitely going to have pools of people that will respect you in midwifery and some people that will NOT—or who have their preconceived notions about you as a midwife. Because I've seen that so much. I saw a lot of that as a nurse and then when I became [a midwife], I knew all those comments and just even people being like, "So do you go to homebirths now? Are you one of those?"* It occurs to me that with this degree of 'othering' that a dual registrant may not feel that she belongs to one, the other, or both professions; rather, she may feel that she no longer belongs to either. That is a lonely place to be.

Welcoming the Nurse Back

Joan shares that over the years, she has returned to allowing the nurse within her back into her practice: *If I've got nothing going on at home and if the unit's busy then I start asking the nurses before I go home—I won't do this if it's bedtime and my husband needs me—but if it's like two in the afternoon and my kids are in daycare and my husband's working, then before I go home I'll ask, "Can I help you?" or whatever to the nurses. And they appreciate things like that.* I wonder what effect offering to help has on the broader relations on her unit. Do her midwifery colleagues know that she does this? How do they feel about this? On labour and delivery, *if I'm done with a woman and I come back to maybe strip my room and I see that there's an emergency going on I'll run in that room and help*. *I have a bit of a more camaraderie friendship with them.*

I note many occasions throughout her account when Joan has demonstrated her generosity as she described above. She didn't want her pregnant nurse friends in the north to have to work nights so she would trade shifts with them. When she worked with nurses and

midwives who were nearing retirement, she often had additional work passed along to her. *I was picking up the slack for years.* Not one to complain, she kicked her robust work ethic into high gear, grinned and bore it. She admits lightly that it has taken its toll over the years.

The Nurse Inside as Seen by Herself

Confronted by strong external beliefs about the nurse in her, I'm curious what Joan believes about herself in her current practice. She has *passion* and *love* for midwifery, and *feels strongly about the care that midwifery provides*. When I ask if there is still a nurse inside her from her own perspective, Joan tells me that the nurse in her comes alive doing tasks *when caring for others* such as a lot of clinical skills that she really enjoys. *If I'm putting in a foley catheter, I have a very specific way I'm going to do it and I do it the same way over and over again.* Similarly, she mentions *giving off report to people* as another experience that connects her to her nurse self. Joan reflects on the skills she refined thanks to the relatively higher volume she cared for in a nursing role. *I got proficient at things like IVs and other things so if there's an emergency I can whip in an IV really quick and I feel confident in those skills.* Additionally, thanks to having worked in several different hospitals, she is fluent in different documentation mediums across a variety of paper and electronic systems, and is strong with using diverse technologies.

Other parts of herself that Joan suspects may be part of her nurse self include how she likes to *keep a room tidy* (which she cites as a safety consideration, in part), paperwork, and *making sure a chart is complete*. I chuckle along with her when she sums it up: *I want to say its somewhat more of the anal things about me*. She ensures *completeness of task* and tries to reduce error by avoiding assumptions: *don't assume if someone says the GBS negative that they're actually negative; you call the LifeLabs and get that result on file*. She shows me her watch

which has a function particularly useful for monitoring time elapsed during a shoulder dystocia. It helps her to ensure her documentation is accurate. She reminds me again of her propensity from childhood for *discipline* and order which is *very conducive to nursing—having things done a certain way*. When she thinks more critically, she is uncertain *if that's nursing or if that's just me*.

Empathy

Many times throughout our conversations, I observe Joan working hard to convey her affection and respect for her colleagues even when she does not agree with their actions or assumptions. She struggles with herself as she tries to communicate to me that she commonly saw nurses and physicians (her kin from her nursing life) put patients into boxes, categorizing them in ways that were sometimes unhelpful, inaccurate or at worst, blatantly harmful. She tentatively offers the contrast of midwifery: *I would see more empathy and understanding that people come from all different walks of life and how they get to where they're at.* And then retracts somewhat as she endeavours to be sure I understand she knows there is diversity in both professional groups. But she allows herself to offer that *midwifery in some ways has way more empathy and understanding. And more empathy and understanding for people to make choices that aren't with the grain.* Different professions are not all good or all bad, and ultimately, *I think people also want to believe that the system that they're in is doing the right thing for people*. These wise words seem to me to be the foundation of Joan's compassion.

Managing Choices Outside of the Community Standard

Having learned that Joan became an advocate for informed choice, I wondered how she managed the tension surrounding community standard, particularly when the client comes into contact with hospital staff and protocols. As a midwife, Joan has become accustomed to clients

making choices that are outside of the medical system standards but finds it v*ery stressful for every party* once the client enters into the system. She recognizes that *nurses are used to people making choices for the most part* in line with doctor recommendations, and the situation becomes difficult if that client is transferred to physician care for something out of midwifery scope.

Demonstrating her empathy, she easily accesses the anger and lack of understanding she felt as a nurse when patients chose care that deviated from the community standard. As a nurse, *I had a client who came out from [a community] who was in midwifery [care] and declining GBS antibiotics. And I was so angry as a nurse. And I realized I just didn't understand GBS. But in MY head, I'm like, "But I actually cared for a baby who is GBS positive and REALLY sick" so I didn't understand why someone would ever decline antibiotics.* This triggers me to reflect on my personal belief that dramatic lived events are experienced as a number greater than one. Negative stories that shock us are told and retold. They live as vicarious trauma to those who are privy the retelling, including to ourselves.

Joan offers a memory about a client declining many routine interventions who developed an obstetrical complication that required an obstetrician to manage. *I told her, "I actually have to transfer care […] so she was really upset. We were hugging, she was crying because she knew now she's going to be in the system. And she has GBS—she tried to do vaginal probiotics and all this stuff. It wasn't working, she was still positive, but she did not want antibiotics. So she went [into the obstetrician's care at the hospital]. I was scared for her because I just know…* Joan trails off. We both know that true choice is hard to come by within the system, especially without midwifery advocacy.

Fear Around Childbirth

Birth Energy

I am curious about other changes in herself when she began practising midwifery. I learn about a fundamental shift in how she experiences and processes fear surrounding childbirth. She shares with me a pivotal memory when a preceptor pointed out to Joan that, *surrounding birth, I had this high energy or excitement at the birth. And she basically said, "You need to tone it down and make that moment calm and special for the parents."* Reflecting on the feedback, Joan realized, *that's how everyone…like, that's how I was trained. As a nurse, there's just this excitement for that big moment of the birth and we're kind of all on adrenaline waiting to see what's going to happen when the baby's born and if it's going to be born crying and all that.* She tells me about staff tension near the time of birth, such as with fetal heart rate changes, for example. *You can hear it in their voice, they're getting stressed, and I've seen it over and over again. And they kind of start yelling at the women. I've seen nurses do it. You know, "You need to push now!"* Reflecting on her preceptor's feedback over her energy in second stage, Joan comes to the conclusion that the energy she and other staff typically bring is fueled by fear. *Obviously we're excited, but my personal opinion is that there's a bit of fear there from healthcare providers in general. [My preceptor] couldn't pinpoint it to that, but that's what it is.* She even experienced it with different staff caring for her own birth.

This revelation sparked a significant change in Joan's comportment in labour. *"It's just changed how I've done it."* While she wholeheartedly appreciates that sometimes a *firm voice* is needed and that energy may sometimes have its space, *I really transformed in midwifery. My coaching completely changed and I removed a lot of that fear I think that I had from the medical system.* She now links staff behaviours to *paternalistic* attitudes that communicate to women that

they are *incapable* and in need of expert intervention. While she gives the benefit of the doubt that staff's behaviours are *not always coming from a malicious place*, rather from a *place of concern*, Joan has nevertheless made a conscious choice to act and speak differently. *Now you'll always hear me saying, "You're so strong. You've got this. You're so strong. Look at you." It's more empowering language. And I've had women give feedback afterwards saying how your voice allowed me to get through that.*

Practical, Healthy Fear

A second layer to Joan's shift in fear of childbirth is the conscious change toward internalizing fear. When recounting a recent story of managing a life-threatening birth complication, she highlights her devotion to anticipating and planning for emergencies at every turn but doing this with an equal commitment to outward calm. *I would say I just internalize it. I always, for a safeness of practice, I think it's good to have a healthy fear around birth. I feel like in our field, when you get too confident, you'll get surprises. [laughs]* Funny how superstitious we all are. *I think, "Okay, what risk factors do we have for PPH here? What risk factors do we have for…?" And that's the healthy fear that I'm talking about. But you don't have to externalize the healthy fear. You don't have to constantly be doom and gloom to the woman who is in labour. It's very much in my mind and I'm giving the women lots of positive affirmations, and I'll deal with the emergency when it comes but I'm always thinking about it in my head. I'm not walking around shaking with fear, I'm just more critically thinking, "Okay if this happens, I'm going to do X*." I wonder if Joan can identify the reason for the shift in her between externalizing and internalizing fear. What helped rework the external aspect of her? *I would say like midwifery had a huge shaping of me viewing women very differently. Midwifery had a different way of looking at women that I really appreciated.*

Reconciling a Dual Identity

As we come to the end of the journey that Joan has generously invited me on, I turn to how she reconciles her dual identity. *I was really encouraged by others to go into [midwifery] but then also I didn't quite expect it to lead me down the path of kind of questioning my identity as a nurse*. She explains that she hadn’t anticipated *this level of reflection* about the care she had once endorsed. Ultimately, Joan has learned that midwifery *isn’t just women delivering in different positions; it is so much more than that.* It’s a profession that *came very naturally* and she is glad to have branched out from *acute settings* into *community roles* with a *broader lens.*

As Joan has taken me through her path from the start of her interest in perinatal care through to present, she has shared many learnings and thoughtful reflections. Joan summarizes, *I learned quite a few things when I went through for midwifery. I felt shame as a nurse that I've been practicing that way. But it also made me feel good that I was on the right side now. So yeah… and I love nursing too. I love nursing in so many ways. I just think back to that women studies class that there's some things that could be done better in the healthcare system.*

Throughout her accounts, I have been moved by how Joan consistently conveys deep respect for her hardworking colleagues across disciplines, while offering a sensitive, critical, concerned eye. She is positive and optimistic—forgiving, but only to a degree. I note how she carefully separates behaviour from the person. She reminds me we are surrounded by good, well-intentioned colleagues who, at times, act in suboptimal (sometimes harmful) ways. We agree that this is rarely out of malice but due to multiple and complex factors not limited to professional culture, training, social forces, or simply the lack of supportive opportunities to learn and think differently.

I have learned so much from how Joan uses gracious diplomacy and genuine empathy for human experience to navigate role tensions and prioritize relationships. I am so grateful for her participation. I know that features of Joan's evolving dual registrant identity story will continue to shape over time as she enjoys the coming adventures of her life.

Chapter 6: Narrative Account for Sarah

I was fortunate to connect with Sarah over three one-hour long conversations over two months. When she first reached out by email in response to my recruitment poster, she introduced herself as from an area to which I had an important historical family attachment. This small detail fed a special affection and curiosity toward her and her identity stories. During our second conversation, she disclosed trepidation about the intensive focus on her personal experiences, knowing they would eventually be read by others. I felt so grateful for her honesty. We both understand that participants are neither expected to push through discomfort nor obliged to continue their research involvement. Sarah's willingness to express her apprehension allowed us to work toward the best fit for her research participation.

As we explored Sarah's research participation, I recognized a theme I have heard from my other participants: a feeling of being torn between expansive authenticity, and a less exposing, sparsely detailed anonymity. I explained that sharing together and then putting experiences to written word are evolving processes, and there are many possibilities for discussing our lives at points in between those two ends of the spectrum of disclosure. I recall how hesitant I was personally to study this topic of nurse-midwife professional identity narratively. I worried about participants' anonymity: these are small practice communities, and the two professions have historic tensions; what can be more personal and even vulnerable than stories of identity? Additionally, I knew that this methodology necessitates my own deep and ongoing personal reflections put into writing. It feels odd and sometimes uncomfortable thinking and writing so intensively about myself. Why should I consider my experiences to be important? What value could sharing about them bring? It seems only fair that I am called on to be at least as immersed and courageous as my participants.

Sarah had already offered so many valuable insights and experiences that as I started to think about how to write her narrative account, I resolved to support her participation in whatever creative way allows her to find her own balance of truth-telling and comfort. I developed a sense that writing in a way that centres my own experiences could reduce the pressure of the spotlight on her. I offer this narrative account to Sarah in the form of personal diary entries. There is so much in Sarah's stories that resonates for me, overlap in questions and tensions we encounter, and important differences too. I pull in her narratives and highlight areas of her identity story throughout. I hope that writing myself in as a companion to her stories will avoid the sense that she is standing alone. We are in this together, living and telling our storied lives.

Entry 1

Dear Memories,

I had so been looking forward to the visit I had this morning with a new participant for my master's study: Sarah. She is an expressive storyteller who often makes me chuckle and nod along knowingly. I delight in how she helps me understand meaning through non-verbal communication. It would be such a pleasure to be in person together for these meetings, yet I am glad for videocalls. I've been thinking about Canada this week. This geographically enormous country; our regional histories; our national values; where the identities of registered nurses and midwives fit into that backdrop.

As we talked, Sarah spoke freely then stopped herself to redirect at times. *I don't know why I'm going on a rant about THIS. Where did I go? I need to, like, circle back and I don't know where I'm supposed to circle back to*[6]. She laughed. Smiling, I warmly protested. I strive to be reassuring: "But it's heart speak. It's good. It's important." I sensed that she was self-conscious about tangential descriptions, a style of speaking that I find rich and fascinating. I think of what a gift it is that participants will allow themselves to follow their own paths as we converse. I recall that Vera, my thesis supervisor, often reminds me that researchers may not know the right questions to ask to bring about reflection on a participant's life stories. With a light and flexible touch to our conversations, participants lead the way to what is important to them. My role is to follow along with curiosity and encouragement.

Sarah suggested that she start at the beginning. *I, like you, also never thought I would become a nurse. So I was a nurse first then a midwife. Currently a midwife. When I was in high*

[6] Note: All *italicized statements* are direct quotations of the participant. Words in italicized *ALL CAPS* are those that were emphasized by the participant within a statement.

school, it never crossed my mind. I learned that, like me, she also had a nurse grandmother. *But again, I had no interest in any of that.* Sarah told me that after high school graduation, she delayed the start of her university education but on the condition from her supportive mom that she *do something productive*. From a close-knit and loving family and with no previous volunteer or independent travel experience, Sarah joined Katimavik.

I had forgotten about this national youth program that my childhood friend had also done. Over several months, participants are placed in three Canadian communities to live with their peers and engage in substantial community-based volunteering. Sarah highlighted this time as *foundational*. She told me, *I think it really rocked my world to be, like, exposed to other people.* She chuckled recalling her younger self. *Especially in a living scenario. Like, people from different backgrounds and different places. It was I think really good for me because if I hadn't had that experience and just went into school who knows…I probably wouldn't have ever gotten HERE but I don't know where I would have been. I do think it was very impactful in how I saw the world and myself.* She went on to explain, *So I think it was like the first thing that kind of was like, "You can go places and do things and meet people and be DIFFERENT then you think you should be" kind of thing.* Sarah told me that she has always had a deep *desire to be different* and *do something DIFFERENT,* especially as she began to differentiate herself from her high school peers. That strikes me as an important driver of the path she eventually followed.

I found that I was curious about how those experiences shaped Sarah's post-secondary education trajectory. *So once I got back from Katimavik I worked a little bit and then I started school. And then I just felt like, what am I doing? I know I need to get a degree, but in WHAT? And like, to BE what? And to DO what? And I didn't want to just be for ME. And I don't think I really understood that at the time.* Not ready to leave her hometown, Sarah studied locally. I

learned that she started university by studying archeology and planned to later pursue graduate education in Library and Archives.

Hearing Sarah reflect on *having started university not knowing what I was doing* reminded me of how aimless I was as well after high school graduation. I knew I wanted to start university away from my small community, and that whatever I did I would do my best to do it well but I had no clear objective. Upon being denied entrance into the International Business program at UBC (I laugh ever thinking that business or finance would be a compatible fit for my interests or aptitudes), I learned from an aunt about something called "Humanities". Humanities! Yes! The word stirred something deep within me. Every ounce of me now wanted to study something called Humanities, whatever it was. And definitely at UBC from which my maternal grandfather and, later, both of my parents graduated.

Promptly, I sent a letter to the UBC Registrar with a desperate plea to reconsider me for the Faculty of Arts for which I met the entrance criteria. Once accepted, I allowed myself the freedom to follow the subjects that excited me most, largely made appealing by charismatic professors. Looking back, I recall the most pivotal course. I would sit midway in a vast lecture hall for my 100-level 21st Century World History class while Dr. Friedrichs interspersed times and events with narrative accounts which drew in human experience. I chose to major in Latin American history which was replete with stories and autobiographical readings such as, "I, Rigoberta Menchu" that helped me to understand human lives as lived in different places and times. As Sarah and I spoke about her education prior to healthcare, I wondered about what initially pulled her toward archeology. Was it ancient human experience, or something different? I find myself curious now about how early education interests fit into identity puzzles of people who are nurses and midwives in Canada.

Entry 2

Dear Memories,

Today I bumped into one of the midwifery students I've taught clinical skills sessions to during intensives. She stopped me to ask why she keeps seeing midwives moving files in and out of a particular drawer that is located closest to nurse and perinatologist offices. I replied, "We don't have an EMR; this is where they had room for us to store our charts." When I answered her hurriedly, I noticed how she lit up with that new piece of understanding in place. Her question seemed banal, but her reaction to my reply served as a reminder that students are immersed in a landscape of mysteries, with little ability to evaluate the relative importance of each dark spot. They move within unfamiliar spaces, systems, language, and social environments which each demand persistent effort to decode. I am sure that it's a joyful reprieve when a friendly, familiar soul tosses a straightforward answer their way.

I enjoy crossing paths with students outside of class, as it gives me a clearer window into their student lives. Over time, I hear about their journeys to midwifery, what excites them, and the challenges of withstanding the demands of the program while juggling complex personal lives. Some students have come from other health professions which adds another layer of interest for me, particularly as I study this topic of dual nurse-midwife identity.

When I met with Sarah last Sunday, she shared pieces about her own journey through nursing and midwifery education that intrigued me. To start, I learned that she had not been familiar with midwifery growing up. *I had never heard of midwifery. Midwifery was not a THING here really.* She first learned about it during her second year of university while watching Ricki Lake's documentary, "The Business of Being Born." I remembered watching it too around 2009. I was intrigued by the way it critically examined modern childbirth practices in the United

States, contrasting medicalized obstetrics with low-intervention alternatives. *That really resonated with me. So, I was like, that sounds interesting—cool. But I'd never been to a birth. Never thought about doing anything in birth.* Sarah's interest was piqued: *I maybe want to do that*. At this time, she did not feel certain about a career in childbirth and was not ready to move away from home. No longer convinced of a future in archeology or library and archives, she turned toward nursing: *a more tangible way of doing something that's actually productive that I can see the impact of daily*.

Sarah explained to me that she applied to a nursing program *with the thought that I probably would become a midwife at some point*. Reflecting on this, I realize that since first learning about Canadian midwifery in 2007, I have considered nursing to be an ideal path for someone who feels they may want to become a midwife later. This belief has been reinforced by a variety of others throughout my perinatal career, particularly in the earlier years. Nurses and physicians I have worked with often suggested that nursing grounds practitioners with a foundation of realism— an essential balance, they believe, to the "idealism" that dominates midwifery culture. Some have said that all midwives should be nurses first. Midwives, however, have expressed more nuanced opinions. Many acclaimed that a nursing background will prepare a future midwife with some valuable skills and experiences; however, I have found midwives far less enthusiastic with an endorsement of nursing education and practice as a seamless fit with Canadian midwifery. As I have grown older, I have become aware that conflicting opinions on the compatibility of nursing and midwifery education have influenced how I perceive my own path.

As I try to consider the pathway of nursing to midwifery more objectively, memories from my nursing program experience come to mind. Unlike Sarah, I had not intended to become

a midwife; rather, I wanted to work in public health with healthy mothers and babies. I found that my nursing education aspired to prepare students with knowledge and skill needed across a wide range of human healthcare needs. It taught anatomy and physiology, health assessment across the lifespan, pathophysiology, pharmacology, medication administration, community health, and a variety of patient care principles and interventions—a few of which served as a useful foundation for my midwifery practice. Additionally, the inclusion of research, health policy, and ethical issues in my Canadian university nursing program helped provide me a broader background in topics related to delivering healthcare in the Canadian context.

And yet, nursing education prepares students to work across the lifespan through a largely medicalized lens. I found it trained me to internalize hierarchy; I learned to follow (and creatively influence) a chain of command to support the efficiency of the system while making my own nursing contribution. For someone who believes their interest lies primarily in maternal-child care, it may be a formidable personal challenge to complete nursing's program requirements that fall largely outside of this speciality. It turns out, this was the case for Sarah: *I hated nursing school. Most of it. I loved labour and delivery. I loved community health and public health stuff. I hated med-surg* (i.e. medical surgical nursing). *I had such bad anxiety throughout all of my placements except I thrived when on labour and delivery*. I wonder what aspects caused her this depth of distress. *In nursing school, I was anxious about everything and was scared to do anything. I didn't trust myself at all*.

Sarah let me in on the additional layer of social anxiety that plagued her at the time: *I was literally scared of going places unless someone I knew was with me*. She paused to consider the apparent contradiction—at the same time, she had become quite the international traveler, driven to explore new aspects of herself and the world. I felt empathy for her as she worked to reconcile

memories of what seemed to feel like opposing emotional realities. I remember the tension of young adulthood as a time filled with transition and discovery.

Sarah's anxieties throughout her nursing clinical placements resonated dearly with me. I recall being surrounded by excited nursing student peers who chattered away during post-clinical conferences about the "crazy" things they saw or did. I was intellectually curious about medical-surgical topics but I wanted nothing to do with them in practice. I constantly worried about performing assessments and administering medications, especially to patients who were not young, healthy, and competent. I shirked from key practice opportunities that pertained to caring for illness and disease.

Placed on a respiratory ward for my first-ever nursing clinical rotation, I remember being assigned an elderly patient dying of lung cancer. I was so overwhelmed by my fear of not being able to care for her properly that I felt physically ill. Nursing students were not allowed to miss placement without a physician's note, so I spent hours in Urgent Care waiting for one. I explained my GI symptoms (true), mentioned the Norovirus outbreak on my practicum unit (also true), but the much bigger truth was that I simply could not face the situation I was expected to learn from. To my relief—(I cringe to use that word)—my patient passed away the day I was absent. My redheaded classmate Jenny had taken my spot and enthusiastically shared with us the details of the patient's death: how her sons, wearing cowboy hats, crowded the bed and cried; the patient's sacral pressure wound that she'd cleansed earlier in the shift; and how she got to help prepare the body for the morgue.

With time I learned that all I wanted to do was work with mothers and babies. Once I was able to focus in that area, I began to feel much better. As I revisit these memories, I feel such compassion for that younger version of myself who swam upstream to the detriment of my

mental health. (I pause here to acknowledge that swimming against the current seems to be in my nature, a tendency I've had a tough time shifting.) It's funny how I haven't thought of those wretched nursing school months in over a decade. My friendships with my tight-knit nursing cohort were strong and beautiful, and I felt I had a purpose and a passion for my budding nursing identity. I think I excused those unpleasant—sometimes intolerable—experiences as necessary trials, accepting them as part of a nurse's rites of passage.

I learned that for her final nursing practicum, Sarah was so keen to continue to learn about childbirth care that she volunteered to travel *anywhere in the province*. She was placed on a labour and delivery unit 5 hours south of her home community and boarded in an old room in the hospital. When she had a day off, she visited her grandparents who were within a 90-minute drive. At this time, new grads were not hired into obstetrics, so she set her hopes on postpartum care. Shortly after graduation, Sarah took a job in the float pool at the hospital that does maternity care. Trying her best to avoid medical surgical wards, she picked up shifts on inpatient mental health. Within a few months, a full-time temporary position in postpartum came up and Sarah gladly accepted it.

From my end, I did my final nursing practicum in an interdisciplinary community-based pregnancy outreach program. I mostly focused on perinatal education and psychosocial support. I loved getting to know the diverse women, most of whom were newcomers to Canada and/or young mothers. I visited them in their homes, saw them at weekly group sessions at the community centre, and checked in by phone over three months. I was already employed as a student nurse in obstetrics and, upon graduation, transitioned directly into an RN role on the same labour and delivery unit. While I graduated with high grades and a passing result on the Canadian licensing exam for registered nurses, I admit that my active avoidance of many aspects

that others consider fundamental to nursing left me in marginal shape as a general practice nurse. I wonder: what features of nursing education and practice support future success in midwifery? Is the path of Canadian nurse to midwife as natural a fit as some believe? What are the challenges along that journey? What ways of being and knowing, beliefs and assumptions, and sense of professional self shape the education experience of midwifery students who were first nurses? These are questions for another day.

Entry 3

Dear Memories,

As I prepare for my next conversation with Sarah, I have been reflecting on her midwifery education experience. I have so much curiosity about this transitional time for her. How did she experience the newness of many areas of practice like out of hospital birth, antenatal care, and informed choice? One of the shared features between Sarah and me is that we both have a history of working as an obstetrical nurse throughout the years of our midwifery education. I picture us with a foot in two worlds, particularly since we both had to travel from home and our nursing jobs for midwifery placements.

After nursing for two years, Sarah applied and was accepted to a midwifery program in another province. She told me that even though she was admitted to the accelerated option because of transfer credits from her nursing degree, she elected to pace her courses in such a way that allowed her to continue perinatal nursing in her home community. When starting midwifery, Sarah was still a relatively new obstetrical nurse, having only recently cross-trained from the postpartum unit. She found the first year of obstetrical nursing stressful. She was in one of the first groups to cross-train from postpartum to labour and delivery after the relocation of maternity services to a new site. Later all staff were required to cross-train, but I suspect being one of the very first came with unique experiences.

Contending with some animosity between the labour and delivery and postpartum nurses, she found the role transition challenging. She explained that the labour and delivery nurses had been there *a long time and they were all very intimidating*. Her stories illustrate that it wasn't a supportive environment. *I was afraid to ask for a second opinion. I was afraid to call the doctors.* Working as a nurse, Sarah *would get all excited when the midwives were coming* in to

care for a client in labour, but she had limited contact with them because of the large number of nursing staff and the infrequency with which the small number of midwives attended hospital labours. She told me stories about being responsible for birthing patients as a new labour nurse and, understandably, not yet having developed specialized clinical knowledge or the confidence to trust her judgment.

I learned that at Sarah's home hospital, obstetrical nurses are trained to give care to patients ranging from lowest risk (i.e., Level 1) to highest risk/acuity. They progress to more advanced levels in a stepwise fashion with experience and on-site orientation. By continuing to nurse exclusively in Level 1 obstetrics, she kept herself away from working in the obstetrical operating room, triage, prenatal wards, or caring for labouring patients with comorbidities such as diabetes or hypertension. As she explained this system, it suddenly occurred to me that I had also worked almost exclusively with a low-risk population after I was hired post-graduation but had not been clear on that distinction. The unit culture was so intervention-oriented at that hospital that I assumed labour management was always complex. On top of that, I was so new to the work that, by the sheer volume of responsibilities, it all felt complicated. It was only once I advanced to higher acuity care that I could really appreciate the differences. I find it notable that Sarah is an obstetrical nurse turned midwife with nursing expertise specific to the lowest-risk labours. I wonder what impact this has on her sense of self in relationship to childbirth care compared with having been trained across all acuity levels and obstetrical care areas.

Sarah told me that she wasn't in a rush to get through the midwifery program, so she essentially alternated semesters of university study with breaks for nursing work. This created a three-year trajectory for completing the midwifery education program. She was elated to be admitted, but sharing her news was met with a somewhat mixed reaction. Her family was

supportive, if surprised. She explained that some staff *were judgey*. One memory that stuck with her was sharing her big news with a midwife who replied abruptly, "*Don't do it*." Sarah recalled feeling taken aback by her response and described an internal sense of defiance in reaction. *Not so much that I'm NOT going to do it, but like, "I'm going to prove you wrong." And like, "You don't know me. This IS what I was supposed to do." Because [the midwife] was like, "Why would you leave nursing?"* While Sarah explains that the two have since talked and she now understands better where the midwife *was coming from* with her negative reaction, I was so interested to hear how Sarah addressed that question: *why would you leave nursing?*

Sarah told me that the midwife seemed perplexed and held the view that nurses have it easier than midwives: *"Like, you get to go home at the end of the day," kind of thing. I think I recognized that as a lack of understanding of what and why I wanted to be a midwife.* She suggests that it shows a lack of understanding for *context*. *I feel like midwives who haven't BEEN nurses look at nursing and are like, "Oh, that's so easy. Because you get to leave and you don't have to be invested in your people like you do as a midwife." And I don't necessarily think people who haven't been in that kind of a care model understand how, um, what's the word…honestly, how disenchanting that is. That's the one thing about nursing that I hated was not knowing. And being such a key part of someone's life to be like, "Okay, bye!" And never... Or even when you're working a shift and then they don't have their baby, especially when you've had them all shift and not getting to see. Or just being like, "I wonder what happened to them."* Yes, for me too—it is so strange stepping in and out suddenly of such a profound time in someone's life. Countless times I also wondered what happened to them.

Sarah and I also have in common a desire to expose ourselves to out of hospital birth early in our midwifery program. She elected her first placement with a rural catchment and a

high homebirth rate. So did I. I was fortunate to be placed on Saltspring Island with a strong and brilliant pre-legislation midwife who blew open my imagination to how birth care can be. We attended families in wild and quirky corners of that stunningly beautiful community whose level 1 maternity services were ran entirely by the one island midwife. I remember sheep; a bathtub under an apple tree; cedar fences around flourishing gardens; eclectic, cozy homes; and endlessly dark and winding hidden driveways. I asked Sarah about her early homebirth memories. At first she replied, *I just remember thinking, "This is nice. This makes sense to me."* She laughed. Then continued with a story I relished for its animation and degree of familiarity that had me see and feel as though I had been there.

First, Sarah gave me context of some limitations of her nursing background when starting her midwifery placement. I learned that depending on the level of acuity and primary care provider responsible for a given patient, an obstetrical nurse at Sarah's hometown site fulfills a changing set of responsibilities. At the outset of her first midwifery placement, *I could not check a cervix. I had NEVER found a cervix. It was deeply upsetting to me.* I smiled empathetically with her. *It was wild. I was working labour for a year at that point and I still could not.* She explained there is an active obstetrical residency program so nurses assigned to obstetricians' patients (who are MRP (i.e. most responsible provider) for the majority of parturients), are expected to call obstetrical residents for all internal assessments. *And I just couldn't find a cervix to save my life*.

She continued by sharing her homebirth memory. The plan was to attend a client at home and rupture her membranes to induce labour which Sarah had never seen used in hospital as an induction method. *So I distinctly remember at this home birth, because we were going to do this rupture and it was something that I was really anxious about. Then the midwife was like, "Okay,*

assess her." And so I did. And I just remember being like, "I FOUND THE CERVIX!!!" and was so excited. We both laugh. *And so she wasn't contracting. We'd ruptured her and she was like, I don't know, two maybe three centimeters. And then we went on this hike in her backyard which was to the back of this rock face and forest, like Canadian Shield rocks. And [I remember] being like, "I did not sign up for this. Why is this happening? [laughs] We were like following her around while we were trying to kick her into labour, and I just remember feeling like, "Where am I? What is happening?" It was really funny.* I watched as Sarah leaned on her hand and laughed warmly at the memory. Taking in her story, I easily connect with my memories of the contrast between institutionalized birth and the freedom I saw in my first placement. *And then we went back and had a baby! It was easy peasy.*

As Sarah tells me stories, she strikes me as a quick learner. Initially anxious about learning certain new skills, she seems to gain confidence quickly. She told me she was *terrified to catch the baby* at birth (something she'd never done as a nurse) but after three births or so, she says, *I was catching completely by myself*. I asked her about the learning in midwifery school. She described it succinctly as *a lot of redundancy and a lot to learn*. As she elaborates, I hear her processing the assumptions she has been faced with from her nurse and physician colleagues about midwifery. *I think that's also why it's frustrating to me after doing both when nurses or doctors or anyone discredits how much knowledge you have as a midwife. Because I find that a lot of nurses think that they know just as much, and I'm like, "I learned majority of everything [in the midwifery program]." The schooling is literally just birth and prenatal. I didn't know anything about prenatal care before I went into it. Like sure I'd been at some births as a nurse. She tells me that their local epidural rate for non-midwifery patients is about 85% and the majority of nurses don't know what to do with someone who doesn't want pain relief.* I appreciate

this perspective, especially having learned that there is no perinatal nurse speciality training required for obstetrical nurses in Sarah's community—this can understandably lead to a narrow view.

I wondered how being a nurse impacted her preceptor relationships. The experience was mixed. She told me, *the fact that I had been working as a nurse—I trusted myself more.* Her preceptors recognized her qualifications and perhaps her confidence. *I think sometimes they believed more in me than I did.* I experienced this too and sometimes I let myself coast on it which posed me challenges as I approached graduation. Sarah described negative assumptions she faced as a student: *My nursing background really helped me in a lot of aspects but it also kind of sometimes hindered me just based on what midwives thought*. She found this notable *because it's always the other way around — "How are we [as midwives] going to be perceived by the nurse and the OBs?" but I felt like when I was in my first placement there was one midwife in particular who did not like me, didn't give me a chance because I was a nurse. She had decided I was going to be, like, too medical.* Sarah explained that that midwifery practice had a homebirth rate and practiced *old school midwifery. They are full-on primary care for three months straight then they get a month off. Like, they ARE midwifery. You don't leave your client even if you're there for 48 hours, kind of thing. Like, it's old school*. She tells me that her preceptor was lovely but the one midwife had made it clear to the practice that she didn't like Sarah—*and not specifically because she didn't like ME—but because she wouldn't give me a chance because I was a nurse, she had like made up these… from THE DAY I got there.*

At this point, I learn an important identity feature about Sarah that was strengthened during midwifery school. Sarah considers herself to be a *very chill* midwife who trusts herself, her client, and birth itself. Despite having a medical background in birth, she insists, *I am not a*

med-wife. Like, at all. She illustrated this by explaining that she is now the midwife that others will call when they have a client choosing care at or beyond the limit of their comfort. *I'm the one she'll call when someone is, like 42+2 and be like, "Will you come to this homebirth with me?"* Sarah answers confidently and comfortably, *"Yes, yes I will."* Now that I understand this, it feels even more unfortunate that the midwife in her student practice came to conclusions about Sarah based on her professional background rather than getting to know her personally.

Knowing that Sarah was traveling back and forth between practice communities and roles in a similar way to me made me curious how she experienced these shifts in place and role. I recall being in midwifery class all week in Vancouver, making the nearly 3-hour bus and ferry commute to the Victoria General Hospital, working 12-hour night shifts over the weekend, then reversing the trip to be back in class on Monday. For clinical placements, when I was placed out of my home community, I nursed on the ward between semesters. Many of my nurse colleagues would inquire supportively how school was going; however, the initial warning from my nurse manager that I should hide my midwifery plans until I absolutely had to disclose them had made a lasting impact. I couldn't quite figure out how to move beyond doubting that it was ok to become a midwife in this community, and that once I did, I could still belong in a way that I had come to cherish.

Though it was a bit of a *blur* for Sarah, she has positive memories of going back and forth between nursing and midwifery. She found it kind of *nice* to be able to *integrate certain things I was learning in midwifery into my nursing. So I think the way I nursed changed I think for the better with patient care.* During the time she was going back and forth, I learn she was teased by a resident for writing *"client"* rather than "patient" in her narrative note. Though she did not appreciate being laughed at for integrating this new language, having previously come to

some conclusions about her lack of respect for this resident from their long working relationship allowed her to move on from the insult.

She highlights that sustaining the relationships with her nursing and OB colleagues at her home site and talking with them about her experiences in midwifery helped to bridge the two professions. *I remember when I first came and said, "I wanna be a midwife" and people were like… uh ok.* Sarah makes a face to convey their suspicion and hesitancy, then she chuckles. *But I think me going through that process and still being…like, not just like "Sarah moved away to become a midwife and then never heard from again"—I've been integrated even throughout the entire time of midwifery school. Because I would come home and OBs and OB residents would be like, "How's school?" and "What's going on?" kind of thing. Whereas if I would have just left and not continued nursing, I feel like it…, like it wasn't as…* She searches for words. *Because I was doing the program simultaneously while I was working I think a lot of people gained insight into what all was involved in becoming a midwife. Which I think was a good thing.* Yes, I feel the power of being a bridge from my experience too. I learn that this set Sarah up for important relational strengths as she approached graduation.

The final months of Sarah's midwifery education had some dramatic surprises. She tells me that she *got in a car accident on the way to a birth and basically got a really bad concussion and couldn't finish* her second semester of her senior year. She made a plan to extend her last placement into the Spring of 2020, but this got upended because of COVID pandemic shutdowns. I remember being involved in supporting midwifery students through the sudden cessation of all in-person education. They were in an extraordinary situation and the clinical world they were expected to enter when their program restarted was shocking at many levels.

Fortunately for Sarah, her midwifery program was satisfied with her level of competence despite her temporary break, and she graduated on time.

Sarah told me about her nebulous transition around graduation which was a non-event due to the pandemic onset. *It was also kind of weird because we hadn't written our licensing exam because we weren't allowed to.* I ask her if she was able to feel like “a real midwife” at that stage. She reflects to me she had the unsettling sense questioning, *Is this real? I don’t know.* There was no ceremony; *We didn’t graduate.* I ask about the transition: *It just happened.* She acknowledges this contributed to a sense of imposter syndrome that dissipated as she got established in a practice.

Immediately after finishing her program, Sarah returned to her nursing position for several weeks. She noted a big boost to her confidence as a nurse *just because I was basically a midwife at that point. I had finished the program.* She considers that had she stayed a nurse and continued to work full-time, confidence in that role may have also grown. *However, I didn’t like NOT being the MRP. I prefer being MRP and catching the baby.* Throughout the three years of schooling, she had also become a second attendant for planned homebirths with the local midwives. This prepared Sarah with relationships with her home community midwives in addition to understanding homebirth processes locally. But, unfortunately, there were no local midwifery jobs. She continued to work as a nurse on labour and delivery until she was hired mid-July as a new registrant midwife back in the community out of province where she had done her most recent midwifery placements as a student. I look forward to thinking about that next phase soon.

Entry 4

Dear Memories,

Today I am reflecting on transition to practice and life as a midwife. Because my senior practicum year took place in part at the same hospital where I nursed, I was asked by my midwifery education program to stop doing perinatal nursing shifts to avoid a conflict of interest. There also needed to be a transition period where my colleagues began to regard me as MRP, not nurse, and I needed to start thinking this way too. At graduation, while I was excited to step into the role of MRP, I grieved the loss of my nursing position which I was asked to resign from to accept a midwifery position. Even though I continued to work with the same colleagues, I felt the loss of being an intimate teammate. Most of my work moved to the community sphere where I mainly functioned alone (which I also loved and thrived on), yet my hospital encounters felt newly unsettled. I loved some aspects of my new role as a midwife in hospital but also missed the ease of fitting comfortably into the system which allowed me to make the most of my caregiving role when I was nursing. I had a lot of curiosity toward Sarah's experience of her transition to registered midwifery practice and learned that in this regard, our experiences largely diverge.

Over my conversations with Sarah, she helped me understand how she experiences herself as a trusted registered midwife with greater confidence and a deep sense that she is providing care that aligns well with her values. *The midwifery model of care has always spoke to me way more than nursing*. To Sarah's surprise, only three months into her new registrant contract out-of-province, a position in her hometown came up and she was hired. With the support of the practice, she packed up and returned home. *And I've been here since*. Sarah has mainly worked in a primary call model which is typical of the practice in her community; more

recently she navigates a new arrangement where she shares call in a team of two. I am keen for Sarah to slow down around this time of her first year of practice. I want to understand the time when she stopped nursing and worked exclusively as a midwife.

The first change Sarah highlights fascinated me: her anxiety immediately eased upon entering the role as MRP. *I trust my ability to identify and intervene more than being afraid of everything.* I'm intrigued by how this can be for her when it felt so opposite for me. She credits nursing for this shift: *I feel like that's because of my nursing background. Whereas a lot of people I think would think it's the opposite— like, you're afraid of everything because you've seen too much.* Instead, Sarah tells me, *I trust my ability to identify the things and intervene more than being afraid of everything, if that makes sense*. I am so inspired by this description.

She also recognizes now that nursing school had not prepared her enough for what she was expected to know and do as an obstetrical nurse, and there was no provincial perinatal nursing speciality program to augment her knowledge. Her midwifery education prepared her with more confidence *to know what I'm doing whereas in nursing I didn't necessarily feel like I knew what I was doing*. *Partly because of the way that [nursing] school is—like, you don't really do that much [maternal-child learning].* Thanks to being placed in another community to learn on labour and delivery as a senior student, *I had more OB experience because it was my passion and I made it happen in school. But there's no… It's a learn-on-the-job situation.*

As she tried to help me understand how her confidence skyrocketed as a newly graduated midwife, Sarah gave me more context from her perinatal nursing days. Expectations of her differed depending on the patient's MRP: *my least favourite was family doctor patients*. This was especially true before starting midwifery education when she still lacked the know-how to manage care alone while the doctor was at home until called for delivery or a problem.

She offered another example by telling me about her uncertainty with fetal health surveillance which impacted her irrespective of care provider. Still a learner, Sarah found nurses—including those in charge— looked over her shoulder and second guessed her interpretation of fetal heart rate tracings. *I had a lot more anxiety as a nurse than I ever did as an MRP which seems INSANE. Because with strips and stuff,* when Sarah was a nurse, *everyone would be like, "Well, these might be lates! Are these lates?"* She worried she was missing concerning fetal heart rate changes that raised alarm about the baby's wellbeing, so she searched for others to weigh in. *And I was so obsessed with that, and it wasn't on the computer at first and we would have to rip off the thing and be like, "Is this okay??" Like not being confident in reading them because you're just learning kind of thing. But also the chance that you read it wrong and then you're going to get yelled at. Or "You didn't do this, this, this." As MRP I feel way less—even IMMEDIATELY as MRP I was less stressed than when I was nursing.*

I am intrigued by this feature which is so different from my own experience. I felt that having someone ultimately responsible for the outcome gave me the security net to allow me to be confident and creative with my nursing care. I didn't have to agonize over navigating invisible rules or double standards that applied only to midwives. Once I got experienced in nursing, very rarely did I get my hand slapped. But not never. I remember pushing with a young nullipara on the toilet who made rapid progress. I helped her back to bed and called the GP promptly for delivery. The doctor took one look at the patient's pushing efforts in bed, then tsked at me with a patronizing tone that even made the patient's mom shoot me a look of pity. "Laura, Laura, Laura," shaking her head. Clearly I blew it and there was no rush at all. I felt relieved when the patient found her power again in this new position, regained her progress, and delivered swiftly after. Rather than feeling ashamed of making a mistake, I felt validated and secure.

Had I been a midwife in that scenario, however, I think I would have continued to doubt my judgement afterward. Perhaps this links to the different degrees to which nursing and midwifery are socially endorsed at my site. Over many years, nurses and midwives have jockeyed for a superior position on the hierarchy, with enduring fallout from their tensions. It seems to me that power of autonomous practice only really works when others validate it too, especially in such a team environment as perinatal care. And perhaps I am too sensitive to the opinions of others.

Sarah tells me how in general midwives, obstetricians, and nurses have had *pretty good relations* at her hospital. Over the time that Sarah has been working, there has been more acceptance. Some of this interprofessional improvement has been thanks to presentations the local midwives give to all the obstetrical residents and nurses during their orientations: *just to be like, "This is what we do, this is who we are, we are educated, we have a different model of care and that's ok."* Prior to that, it seemed to Sarah that staff had a poor understanding of who midwives were and what they do.

She explains that this misunderstanding has been made worse by birth care by unregistered providers in her community. *There has always been a decent amount of people or this kind of [motions then speaks more hushed] doulas that support unattended birth and/or deliver babies when they say they don't, kind of thing. So that's always been to some degree happening. It's also a new wave right now.* These practices create tension for regulated midwifery when judgements from underinformed staff bleed into their perceptions of educated and registered providers. But Sarah has a unique quality to her hospital relationships. *I feel I have always had a bit of a… I feel that I have a weird kind of perception of it because I was ONE of them* [i.e. the hospital staff]. *Like, there is a lot of trust for me because… there has always been*

that [belief] that, I don't know, "sometimes the midwives do weird things and are kind of rogue." She explains that because of the local midwives being very small in number and mainly doing homebirth, there was little contact over normal cases. *The only time they ever see people from homebirths is, either they were unattended and things didn't go well, or we bring them in because something is happening [that needs extra care].*

Sarah enjoys the benefits of knowing the documentation, systems, ward, and staff well *having worked with people day in and day out of shifts* over four to five years before starting independent midwifery practice. That was true for me too. I had warm and supportive relationships with nursing, physician, and management colleagues. During my first four years of midwifery practice, there were very few new hires during that time so most knew me "the midwife who was a nurse." When I met someone knew, a nurse would often introduce me as "used to be one of us". Oddly, when I was away from both midwifery and perinatal nursing throughout the pandemic, I returned as a perinatal nurse after 8 years out of that role to the ward that had experienced more than a 50% staff turnover. I was taken aback to hear new colleagues say, "oh you must be the midwife who is now a nurse with us." At some point, my identity switched to midwife among my peers, and I had not realized it.

I asked Sarah how she makes sense of her rapid transition to confidence upon taking the role as MRP. *I think I just have a lot more confidence in my abilities and knowledge, and I think I also over time have gotten less… fearful. I feel like before it was ingrained to be fearful. I was also dealing with way more people on oxytocin and still low risk but higher risk in that now I deal mostly with people who go into spontaneous labor.* This reminds me of Sarah's high level of comfort with out-of-hospital birth and her view of herself as a *chill* midwife.

For me, homebirth was an area I really struggled to learn to be comfortable with. Before midwifery, I had only seen babies born in high resource settings with specialized obstetrical and neonatal capacity onsite. I was not used to having so little support and being so alone as midwives with labour at home. Learning to become self-reliant has been a challenge. I had a hard time weaning myself from the people and things that helped me feel secure and capable. However, objectively, my hesitancy toward providing care at homebirths does not render them any less safe or reasonable than the quality research evidence suggests. I still yearn to align my inner comfort with this supportive research evidence. I know I will continue to wonder on this topic, among others, in these coming days as I think about Sarah's valuable stories.

Entry 5

Dear Memories,

My time speaking to Sarah is coming to a close. She said something recently that made an impression on me: when she was in nursing she felt*, I like it enough. I'm where I wanted to be. I do postpartum, I'm doing labour and delivery. I COULD do this. But it just didn't feed my soul like midwifery does.* I feel pulled to spend some time thinking about what feeds my own soul professionally, and what I have learned from Sarah. It seems to me that these may be important features woven into our identities.

One feature Sarah highlighted that she has embraced within midwifery is autonomous practice. She is glad to be free of nursing where she was not viewed as *autonomous* in care. *Now I feel more confident being like, "This is what I'm doing, this is my plan and if you don't agree with me, cool, tell me but..." Whereas then it was more like, "Okay, this is someone else's patient and so I have to do it to their expectation" which would give me more anxiety.* She is over her fear of calling colleagues for consults, partly because she got practiced as a student midwife *calling OBs who weren't very nice*. But it is also now because *I call them when I need them because something is happening, I've already identified it, and I know it.* I enjoy the self-assuredness and clarity in her voice.

Another area that has made an impression on me is Sarah's deep resolve for the core midwifery tenet of informed choice. As she describes her dedication to this topic, I heard her strength and confidence in herself as an autonomous care provider which I have come to believe is the unspoken but necessary compliment to informed choice. A care provider who embraces their autonomy creates the conditions to support informed choice. Without taking hold of

autonomy, I have found it very difficult to navigate client decisions that run counter to community care standards without succumbing to systemic pressures.

Sarah illustrates her passion for upholding informed choice when explaining her views on an aspect of homebirth that is controversial among some Canadian midwives. *This is a thing that's so hard for me in conversations about whether we offer home birth, whether we do this or do that—a core tenet of midwifery is informed choice. And we have to let people make their decisions. WE can give them the recommendations about what is the safest for them. But here we have this whole unintended birth policy that essentially if you decide—say we're like, "You are not suitable for home birth"—and you decide to do it, OR you decide you just want to have a baby by yourself and not call us, there's some midwives that think we should completely sever ties and not do postpartum care. Which I, in my core, don't believe in. Because if we truly respect people's informed decision making, just because it's something I don't like doesn't mean…* Sarah trails off but her message is clear. Respect for informed choice cannot involve midwives wielding their personal opinions or enacting disapproval.

I learned another feature of Sarah's professional identity through reflections she shared with me about navigating her work with obstetrical nurses when they are assigned by policy as a dedicated nurse to all labouring patients in hospital. This is Sarah's value of being with and caring for her clients as an essential part of her midwifery role. Sarah told me about midwives' hospital work in the two different provinces she's worked in. *When I was in [the other province], you just did everything* for the labour without nursing support and would *call in the nurse just for delivery just in case you need to resuscitate basically. And then they're like, "'kay, bye!" And then you do all the postpartum.* She tells me she became used to that minimal nursing support and was still fluent in fulfilling the nursing role herself.

In contrast, when she became MRP at her home site that had 1:1 designated RN care for all inpatients irrespective of their primary care provider, *it was kind of like, "You're here now, I'm here, we're both here—what do we do?" Because [management has] really pushed that [midwives are] supposed to be treated as any other primary care provider is. So you have a nurse, which sometimes drives me crazy, but I know other midwives will [say to the nurse], "You do everything."* But then Sarah wonders, what is the midwife *doing*? She feels she can't just sit back *over in a corner* for that long while the nurse does *all the heart rate checks and all the vitals and all the things*. Even adjusting her role to only *labour support* doesn't sit right to Sarah who doesn't want to do that exclusively either. *Because that's also bizarre because that's what a doula's role is*. *So now you think I am MRP but also the doula. I don't know, I just usually say* [to the nurse], *"I do a lot of stuff. You can fill in the gaps or I'll ask you to do what I need you to do," kind of thing*. She sees herself and her role as encompassing obstetrical nursing roles plus all the aspects that make her a midwife.

She points out the important feature that I have highlighted in my work too—when the standard is set for nurses to treat midwives "like any other care provider" they fail to consider the important difference that *any other care provider isn't in the room* throughout the labour like a midwife. I ask Sarah if it is important to her to do what some people might call, "the tasks" (e.g. fetal heart rates, maternal vital signs, repositioning). She answers me bluntly. *Well, it's part of my JOB. So, I'm not delegating it for no reason just because they're THERE. That's weird to me. It doesn't make sense to me.*

I feel such relief to have someone to talk through this aspect that has been an area where I have held different reservations and opinions from my local midwife colleagues. Despite a provincial standard to the contrary, my local obstetrical site does not yet have dedicated 1:1

nursing for all patients irrespective of care provider but midwives are lobbying hard for it for a variety of valid reasons. It is a tense topic here. Asking differently about tensions feels subversive and unsupportive of midwives' genuine concerns about inequitable nursing support for their clients.

As I hear Sarah's experiences and consider my own, I realize that being forced to negotiate with nurses over overlapping roles effectively solidifies some aspects of our professional identity as midwives. I share with Sarah that for me, delegating pieces of care including tasks separates myself from the client which doesn't feel right. To me, taking care of people is an essential part of being a midwife. I sense that she and I share this in common and she elaborates, *I don't know if it's partly just because being from a nursing background that that's important to me or that's what I identify as what you should be doing as part of your job. I don't know. But there's also midwives that I know that are comfortable just being like, "Okay, I'll go sit at the desk and you do everything." Like that just isn't..., that's not what midwifery IS. If I wanted to do that, I would be a doctor. Like that's the difference. And also at HOME you do everything. So just because we're in [the hospital]—that's the, I think, part of the disconnect for me is like, "Why does everything change [in the hospital]?" And I understand that the nurses feel like, "but that's my job and I need to do stuff" but its MY client. I know them. It makes more sense for me to do the things.*

Another related aspect of her identity as a midwife today that inspires and uplifts me is Sarah's joy of continuity of care. This has me recall my first doses of continuity of care when I started teaching prenatal class as a new nurse, and I looked for people who I had taught when back on the labour ward. I loved knowing a bit about them and their priorities in advance and supporting them with their hopes for childbirth. Even as a student, I loved seeing the women in

their homes and in a community space. While it is exhilarating in a way to succeed at the challenge of forming an instant and trusting bond with an unknown family, being a familiar person has a profoundly different quality.

For Sarah, continuity of care goes beyond what I consider typical of midwifery care because she practices in the community where she was born and raised. *It's been cool too because people I know from life and stuff have become clients. Like people I've gone to highschool with, or friends of friends. My little sister's best friend was just in my care. So it's been really cool to be HOME and be able to take care of people that I know.* Additionally, she gains satisfaction from the way midwifery allows her to sometimes stay connected with clients over many years. *I love being able to develop relationships with people and see them through. I have now some people that are on their third baby with me.*

Through Sarah's generous reflections on her journey to maternal-child nursing through to midwifery, I have been offered many rich opportunities to think about professional identity-making in dual practitioners. Some areas of overlap between Sarah's stories and my own have prompted me to think more deeply about what features feel true, or how they have shifted over time. Similarly, our differences have opened my mind to thinking differently, including about possibilities for growth in the future. I hope that Sarah feels my gratitude for her contributions to my journey of understanding nurse-midwife professional identity in the Canadian practice landscape.

Chapter 7: Narrative Account for Lauren

At the time that I start this narrative account for Lauren, I have enjoyed three video conversations with her over three months. I am drawn to her inquisitiveness and insights around professional practice issues, history, and sociopolitical forces affecting both nursing and midwifery professions. When I learned that she is also a graduate student, I felt my sense of our relationship shift toward something closer to that of peers. Lauren has given me the gift of both her personal stories of maternity care in two roles, as well as sharing her discernment and intellect.

Speaking to Lauren brought my attention to a void in my educational experience that I had not consciously appreciated until our meetings: I have had no graduate student peers with whom to examine issues of hybrid nurse-midwife professional identity empathetically—in a knowing-through-living sort of way. I am in a Master of Nursing program where the coursework understandably focuses on Canadian nursing scholarly and professional practice issues. Two years of valuable engagement in relationship with fellow students and faculty on important professional nursing topics have resulted in sharpening my focus on one part of my identity, perhaps at the cost of overlooking its interconnectedness to the other. My conversations with Lauren, exchanging experiences of living and thinking deeply about midwifery professional identity, yielded new questions and insights that have filled some of this gap.

I have reflected on how to best capture in writing my relationship with Lauren and the qualities of her identity stories. I am drawn to try to both represent and continue our dialogue which is why I have chosen to write her four personal letters. I hope they convey the depth and breadth of impact she has had on my thinking about our professions, and the degree to which her

personal stories have triggered meaningful reflections about my own paths and beyond. I am so grateful to Lauren for her generous contributions to this research.

Letter 1

Dear Lauren,

I've been thinking today about our roots as midwives who are nurses too. When we first started talking, you shared that you had always been interested in health and chose nursing for practical reasons. As our conversation unfolded, I came to see there are important features in your story that live in the spaces between those two points. You had long had thoughts of becoming a physician. When you told me this, I was reminded of how my mom often recounts my childhood visits to our family doctor for routine check-ups. Apparently, I asked the what? and why? of all her assessments and equipment. The doctor told my mom, "She'll be a doctor one day." Or was it, "I bet she'll work in health care"? Might she have said, "She will become a nurse"? It surely would not have been, "She'll be a midwife!" There was no established way in Canada to do that in the 1980s[7].

I recall that inwardly I chuckled warmly when you introduced yourself to me as a *very practical person*[8]. I admire practicality: those who ask, "What makes sense? Then let's do that!" Concluding that your grades in the prerequisite *hard sciences* were not high enough for admission, you took the path toward humanities. *I'm not going to get there. It's not going to happen.* You disclose to me the part of you now that says, *boy, I should have just gone for it back in the day and become a doctor or really tried*. I'm curious about this part—did you give up too easily? If midwifery now afforded you a broader scope, would this satisfy you in your career

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[7] In the 1980s, no province or territory had legalized, regulated midwifery services in Canada. Of note, midwifery demonstration projects emerged at this time in a spattering of centres across the country as pilots to evaluate the safety, effectiveness, and feasibility midwifery as an alternative to the medicine-nursing monopoly on perinatal care (Burtch, 1994).

[8] Note: All *italicized statements* are direct quotations of the participant. Words in italicized *ALL CAPS* are those that were emphasized by the participant within a statement.

more fully? I learned that the idea of becoming a nurse practitioner with the scope to provide well-baby care appeals to you, although you believe that that is now an unrealistic dream. I wonder what other areas interest you.

You told me about your honest early views of nursing that you admitted to being somewhat unfavourable: *I thought that nurses were perhaps subservient to physicians. They lacked autonomy and responsibility and I (…) was NOT into that.* You laugh. As you shared your early impressions from your younger years of nurses' disempowerment, I realized how little I was aware of this perspective early on in my life. I recall the confident, capable Public Health Nurse named Margaret who came regularly to our home to support my disabled mom during my sister's newborn weeks. In my five-year-old mind, no one was more powerful.

I listened as you offered a counter example of nursing identity inspired by your dear Granny. I learned that she nursed in Saskatchewan and then across Canada in a variety of practice environments including labour and delivery: *[…] she's been a person who I've always really admired and looked up to. And so, I think that felt really…, yeah, having that role model in my life felt like a…* I listen to how you carefully select your words. *I could see that she had done a lot of good in her life and made a difference for people, and that felt good*. I watched you contend with this tension as you skillfully hold both true—your doubt and your recognition.

I felt a surge of excitement in me when you introduced your Granny. I wanted to tell you but held back at the time in favour of curiosity for your personal story—my grandma became a nurse in Saskatchewan too. She died last year at 98 and during this thesis project, I think about her and her influence on me often. After finishing school, my grandma left her rural farm where her parents had been homesteaders and moved to Prince Albert where she did her nurse training. What about yours?

In contrast to the loneliness of isolated farm life, my grandma told me stories of living with the other nurses and the adventures they had together. Or did I just imagine that through her tone and the brightness in her face that conveyed that she remembered those years so fondly? Yet, as you say, *it was based at a hospital. And you lived there and you were—as a young woman—you were kept [pauses] under surveillance [laughs gently]* w*ith curfews and rules and a lot of free work. So yeah, that history of nursing has always bothered me a little bit*. Indeed, I can just imagine the treatment our grandmothers received from doctors embedded highest in the hierarchy who were perhaps their primary teachers. You highlight that this was a time prior to an established nursing body of knowledge with professional nursing identity still in its infancy. You're right, there is much to pause over about this history.

You told me how you saw the legacy of your Granny's training in your own nursing education: *I remember particularly being taught about how to phrase things to a doctor so HE would think it's HIS idea.* My goodness, The Patriarchy! You and I both laughed over our shared memory of the nursing laboratory day dedicated to learning to make beds with mitred corners. I see your dismay. Again, another buried memory surfaces— while visiting my grandma's house my own mom (who has no healthcare education) taught me to make a bed and insisted upon clean "hospital corners." Perhaps she was striving to meet her mother-in-law's standards. I hear you offer these examples to explain your ambivalence: *I felt uneasy with nursing*. How is it that the flavour of nursing I got from my earliest years was that nursing felt like independence, autonomy, meaning, and connection? I somehow missed those other parts.

As I write this to you, I begin to wonder if my grandma's happy memories of nursing are contrasted with more repressive memories of her school-aged years. I imagine her as a female only-child with far more intelligence and initiative than available opportunities while she lived

under her parents' roof. And then, given that she did not continue to work as a nurse once she married, perhaps her professional identity offered a contrast to the often invisible and largely taken-for-granted work of a mother and homemaker. While I am searching for her truths, knowing that they set part of the foundation for my own perception of nursing, I am sensitive to just how much may be only my own imaginings. I wish I could have these conversations with her now. I wonder how knowledge from our earliest years including our grandmothers' influences shape our experiences of our own nursing identity.

This is only the beginning of my wonderings from our time together. I look forward to writing you again soon.

With warmth and gratitude,

Laura

Letter 2

Dear Lauren,

Yesterday in prenatal clinic, a father asked me how many families I've helped give birth. I imagine you've been asked many times too. I haven't kept count—have you? I wish I had written more stories to myself over the years, especially from those early months as a student nurse on labour and delivery. I want to remember how I navigated the gap between the vision of childbirth I learned from a guest midwife lecturer in my maternity nursing class and what I witnessed on the unit. That midwife had been invited by my maternal-child nursing professor to teach my class about labour. She showed us Penny Simkin's "Relaxation, Rhythm, and Ritual," a video about coping in unmedicated labour. (Of note, I credit those scenes with singlehandedly setting me on a career path toward birth work. It truly captured my heart.) This view presented its own challenges as we received so little additional labour and birth education that I was unprepared for the extent of interference in birth as a physiologic process. During those first months, I was in awe of the human body's capacity for growing and birthing new life—and equally struck by the care team's elaborate protocols. Early on, it all seemed quite cryptic to me. As a learner, eager to catch up and keep up, I leaned in hard to what was expected of me.

During our first conversation, I learned that you and I were both educated as nurses through accelerated, post-degree nursing programs in the same province and at the same time. Prior to considering a nursing career, you completed an undergraduate degree that fed your new passion for *social justice*, *feminism*, and *history*. During a university summer job, you learned about midwifery through a visiting pregnant woman who was receiving midwifery care in another province. *So, I got to know her and was FASCINATED by this profession*. I found it special that you remember her as pivotal in your evolving identity story, as those conversations

led you to dive deeply into understanding Canadian midwifery. *I read EVERY book I would say that summer that the [university] had on midwifery. History of midwifery. I read people's masters theses and PhD dissertations […] So I really read all of that and I was like, this is… this is my path. This combines kind of all of the things that I'm really interested in and it feels like really important work. And I think I could do it.*

At 22 years old, you took a shot at this new dream and applied to a midwifery education program. Unfortunately, you were not accepted on your first attempt. *I was disappointed at the time but also not wholly surprised.* We both know how competitive the programs are, and how prior experience in maternal-child care can strengthen an application but at this time, you had none. At this point, you consider your next steps. You were *interested in healthcare* and focused on *employability*, seeking a career path that would lead to a well-paying job soon after graduation. You considered that nursing could be *helpful* if you *decided to pursue midwifery*.

At first, I was surprised when you told me that you weren't intent on labour and delivery when you started in nursing. I had assumed, since you believed you would love midwifery, that nursing might have seemed like a natural alternative. Yet, I believe I understand now that you made clear distinctions between nursing and midwifery from early on. Rather than viewing them as interchangeable, I sense that you never confused the two roles. Have I understood this correctly? I remind myself that your affinity for midwifery was present before nursing school—and that feels like an important quality of your evolving identity story to keep in my mind.

I listened as you described how you encountered hostility toward midwifery during your nursing education. I felt pained as you told me, *we had a lecture from a labour and delivery nurse who came. And they just kind of spread all kinds of misinformation about midwives. It was SO BAD. And also, again, bringing home those negative stereotypes about, you know, "You can't*

plan a birth and people who try, they're just going to have a c-section." That was the education we experienced in this program—so negative. The judgemental messages you received were (disappointing and unfair) contrasts to what I was exposed to. As a result—for better or worse—it took me longer to fully recognize the underlying tensions surrounding midwifery in that province at that time. Your story highlights how much impact a single lecture—even a single educator—can have on shaping students' beliefs, attitudes, and how they begin to envision themselves in relationship to the new world around them.

Lauren, you shared that your final nursing practicum took place on a labour and delivery unit in an urban hospital. As you described what you saw and experienced, I felt a sense of shared disheartenment. *The culture around birthing was just pretty negative. And it reinforced some of the negative stereotypes that, as I said before, you might have around a medical model of birth. Like people joking about a birth plan that someone would bring in.* Yes, I remember witnessing this too, many times. I believe I pushed those memories aside, choosing to focus instead on the positive aspects of my colleagues. Maybe that was denial in action—or perhaps a strategy for self-preservation, and a way to avoid conflict. As a new nurse at the bottom of the hierarchy and still highly reliant on the support of my colleagues for mentorship and practical support, I could not see a clear path to challenging the attitudes and behaviours around me. Here is a layer of additional honesty: I think it isn't in my nature, though I wish it were. Negativity notwithstanding, I wanted to stay on that ward and do good quietly in my labour rooms with my patients in my own way.

As you told me about how the nurses you worked with during your senior practicum often left labouring patients alone in labour, I felt sick. While short staffing meant one-to-one nursing care wasn't always feasible, you explained that when it was possible, it still did not

happen. *My preceptor and I were often at the desk when we would have someone in labour.* I was taken aback by this description. You and I trained in different cities, and at my site, nurses were expected to remain with their patients throughout labour. I learned from you that continuous nursing support was not the standard of care where you worked as a student, *and there wasn't leadership or culture to support that.* You told me that when you and your preceptor were assigned patients, you weren't *surprised that most of them wanted an epidural. Because I knew, well, they are in their room by THEMSELVES. No wonder. This is their first baby. They're struggling and no one is…they're not receiving any assistance. They're going to need help even if their intention wasn't to use pain medication. So, anyways, it wasn't a very positive experience.* As I listened to you Lauren, I began to see how early you developed the ethic of being "with woman"—someone who offers presence and centres the families' needs. It is an identity you clearly saw as distinct from the obstetrical nursing role you were first introduced to.

As we continued to talk, I noted your attunement to the politics surrounding midwifery in that province—especially when you described how, from your vantage as a student, your nurse colleagues viewed midwives. You pointed out that at your site, *there were no midwives there unsurprisingly because midwives didn't have hospital privileges. That was kind of coming when I was in my placement and there were a few nurses who proclaimed that they were going to QUIT if midwives got privileges there.* I was struck by the power and emotion in those threats. Despite you and I being in the same region during this pivotal time—when provincial public funding for midwifery was just beginning—I do not recall conversations at my hospital about midwives gaining access to provide care. It occurs to me that hospital privileges for midwives may have been granted earlier where I worked, possibly closer to the year 2000 when those provincial discussions began (Vlessides, 2000). Even so, until you and I graduated from nursing, families

had still been paying out of pocket for midwifery services which kept their numbers of hospital encounters quite low. Whether midwives were already present or only just arriving at my site, in talking with you I realize I was largely oblivious to the politics surrounding midwifery at the time. I had no awareness of the hospital tensions you had come to understand through your personal research a couple of years prior.

When midwives did attend births at my site, I had the impression that staff essentially ignored them when they came in with clients. Typically, they required little interaction with nursing though I do not recall sensing a positive regard from staff. Maybe neutral? —no, suspicious, at best. I had next to no contact with midwives in hospital apart from responding to a call bell and unexpectedly entering the scene of a "toilet birth." I found the dripping baby in the laughing midwife's arms. I was flooded with questions: Why was this baby not at the warmer!? All babies go directly to the warmer for assessment, no matter what. Why is the mom and dad still embracing joyfully in the bathroom and not in bed to deliver her placenta? Did they even give oxytocin? What is going on in this room?! They clearly did not follow our rulebook. I was baffled.

As you approached the end of your student placement, you felt sure you would not continue in labour and delivery at that hospital b*ecause it was too negative.* I was moved by how you summarized your time there: *it confirmed all of my suspicions. And, you know, because it reinforced everything that I'd read about the hostility that the medical system and the violence that could be perpetrated on women's bodies. It confirmed those things.* Further, you told me that if you remained in that region, you'd likely leave obstetrics altogether. *And like, I really didn't fit in, there were, as you know, within nursing culture, it's very…there can be a lot of lateral violence.* You shared how you observed that dynamic play out among the nurses—*those who*

were a little bit different and didn't completely tow the line—I felt that would be me if I worked there. I wouldn't have any friends, and nobody would like me. You laughed gently, imagining that the charge nurse would give you *the challenging assignments every time.*

Once I understood how awful your student experience on labour and delivery had been, I felt very surprised to hear that you decided to apply to work in obstetrics out of province—what made you want to try again elsewhere? To your *amazement* you got hired at a large tertiary care centre in British Columbia. You told me that it felt like winning the *lottery* to get a *full-time permanent position*. Part of the appeal and joy was being able to train at a technical school that prepares registered nurses for perinatal nursing specialization. You described the experience as wonderful and completely *opposite* to where you had started.

I felt uplifted by your experiences in this new province and new hospital where you experienced both your nursing role and midwifery in more positive ways. You explained that this context helped you to remember your *passion*. Your contact as a dedicated one-to-one nurse for midwifery patients gave you important insight into midwives' work and ways of being with clients. *[I] saw midwives working and [felt] like, wow, I really want to be a midwife*. You described that part of a reignition of your interest in midwifery was the pull *toward relationships with clients that are longer term*. *I think that one thing I recognized in my nursing role was that I really wanted to be able to support clients a bit better by knowing them better. I had so many people who would come into hospital too early, getting admitted too early, which I found frustrating*. I empathized with you when you described the frustration of being assigned a patient who was not in active labour and would have been better off at home. In those situations, as nurses we know we will be with the patient *all day,* and I sense that both of us doubt the value to the family of our involvement and the institutional setting at that early stage.

Additionally, you described caring for patients who arrived at the hospital with specific birth wishes but inadequate information and supports leading up to labour to help them achieve their goals. You cared for *people who didn't want an epidural but had done no preparation and didn't have any knowledge about how to cope in labour without that.* I tend to agree with your reflection: *I think when you've arrived in labour, it's too late*. *Most of the time.* I also heard in your story a growing desire for more *variety* in your work, and the ways the repetition of nursing labour care began to wear on you. *I disliked working with laboring people for 12 hours every day.* You explained the intense pace you were required to keep. *That [hospital was] such a busy facility—especially when you're a junior nurse, you will always have an assignment when you come on shift and then once your client has delivered you get somebody else. And that felt just exhausting.* Midwifery, by contrast, offers care across the full spectrum of the childbearing journey and across multiple settings. *So, I felt like midwifery might be a way to kind of engage in this work and feel better about it*. You decided to apply a second time to study midwifery.

As I reflect on your stories from nursing, I sense a strong shift that occurs— a turn toward midwifery in hand with a turn away from nursing. Once accepted into a midwifery education program, you moved to Ontario and enrolled in an accelerated stream designed for people with healthcare experience and an undergraduate degree. The others in your small cohort were also nurses. *And because we were in our own stream within the program, we joined a few different cohorts along the way. And so it really felt like the people that I was truly in the program with were these two other women*. You recall having talked often with them about your nursing backgrounds as the shared context for your transition to midwifery, but you do not recall particular topics.

I found it interesting when you reflected that you were all relatively new nurses with a couple of years of full-time practice at the time you entered midwifery education. You pondered, *I wonder if it would have been more difficult to make the transition from nurse to midwife if we had been VERY steeped in nursing practice for a really long time*. That is an interesting point and perhaps there is a difference between people like you who imagined a future in midwifery prior to nursing and those who discovered it later. These may be additional qualities that shape our identity puzzles.

I am grateful for the chance to reconnect in a follow-up conversation over unanswered questions about this formal transition time from nursing to midwifery. I learned you *resigned* your nursing position because you had to move across the country to study midwifery. The distance was too great to stay on as casual though you suppose that had your midwifery studies not required relocation, perhaps you would have continued to pick up some nursing shifts, at least for a while. Something about your confident, resolved tone gave me chills as you recalled, *I was very cognizant that it was my last nursing shift and maybe forever. At the time. I took a picture of myself actually—I got someone to take a picture of me on the unit. In my scrubs. Because I was like, "This is it. I'm going to be a midwife now."* I imagine you turning forward along your new path and not looking back.

As it turned out, you nearly went back to nursing out of necessity after graduation because midwifery jobs for new registrants were hard to come by in the region you had settled during schooling. You obtained an active nursing licence for that province, applied to several obstetrical nursing positions, but it was surprisingly hard to get a job. *I don't know if people saw that I had trained as a midwife and were like, "no thanks." It was surprising actually how challenging it was* [to get hired]. After 6 months, you were offered a nursing position which you

turned down after gaining midwifery employment that same month. So, you did not nurse again, after all, and you no longer have a practising nursing licence. Officially you are now all midwife. I wonder if that is how you feel about yourself as well. *I think your observation that I've kind of left nursing is true, I would say. I don't conceptualize myself as a nurse.*

I find myself curious about this transitional time as you first experienced midwifery from the inside. How did you find learning and implementing informed choice discussions? What was it like to attend your first home births? How did you experience your clinical placements? What was your first year of practice like? We didn't get to these conversations.

Another transition point I was curious about was when you returned to the same hospital where you had nursed full-time in labour and delivery for the three years prior to starting midwifery school. I wondered how you experienced reconnecting to the space and people where you had worked in a different role. *It was really helpful for me to come back to the community as a midwife and reintegrate into [that hospital]. The policies hadn't changed that much. I was very familiar with the institution. I knew a lot of the nurses who were in kind of leadership roles. And that was, I mean, as a new midwife in the community, like, that's such a gift. I had a lot of trust from them right away in a way that you probably wouldn't have if you are [new] midwife—well, I mean, that would develop over time—but if you're new midwife coming there, people don't really know you.* You explain that your practice focus has shifted such that you infrequently provide hospital birth care, s*o, it is helpful if I have a relationship with somebody who's working on shift. And that's often true.*

I found it interesting when you named one tricky aspect of transitioning to autonomous practice: assuming full ownership of care management as the most responsible provider. *In nursing, you have a lot of responsibility, but you're not the person in charge. You have levels of,*

you know, hierarchical reporting procedures that if something's wrong—you know, you identified an issue—you're going to talk to your charge nurse or you will phone the resident who will call the OB. But when you're the midwife, you have to be the person who's—you have a lot more responsibility and you need to make more decisions. And so, for me, that was hard. That was hard to kind of really take on that responsibility and own that. I empathize with this experience, Lauren. You continued, *It took me YEARS into my professional practice as a midwife, for sure, to really feel more comfortable with taking on that authority.* It took me years too. Even now, I tend to lean toward consensus and compromise which can make autonomous decision-making challenging.

While I often felt drawn to ask for more details to illuminate those earlier parts of your identity story, following your lead toward topics you prioritized helped me to understand what matters most to you on this subject. What followed our overview of your path into midwifery—your insights into professional practice, formal support structures, and future opportunities—brought much richness to dimensions of identity I had not previously considered. I am so grateful for the way you've welcomed me as a companion in these present-day and forward-looking reflections. More on that in my next letter.

With appreciation,

Laura

Letter 3

Dear Lauren,

A midwifery student approached me today to ask if I would consider being her private tutor. I hoped she was looking for support with clinical skills, where I currently feel strongest. Instead, she wanted help reviewing complex management scenarios. Since stepping away from full-scope midwifery care five years ago, I'm no longer current in that area. I declined, realizing how much confidence I've lost in that part of my practice. Speaking with the student brought back memories of my own healthcare education and reminded me how much sustained effort it takes to maintain clinical knowledge after graduation. Similarly, in December I had to step away from perinatal nursing because unit leadership rightly flagged that I had not worked enough obstetrical shifts in the past year to maintain competencies as a casual employee. Balancing full-time studies had made it difficult to keep up—especially during a period of major electronic documentation changes in hospital. Though childbirth is as old as humanity, practices and protocols in our line of work shift constantly.

Keeping up with current standards is an ongoing challenge, and I've come to believe that competence and recent patient care experience are central to my professional sense of self. Especially with my midwifery role, I don't feel I can stake a claim based solely on my registration or job title; it's regular, hands-on practice that makes me feel like I AM the letters after my name. When my perinatal nursing role was questioned in December, it hit me personally even though I agreed entirely with the decision to take a formal leave until I can come back regularly. Though I plan to return after graduation, the loss—albeit temporary—underscored how closely I tie practice to identity.

Currently, my midwifery role is limited to antenatal care which covers just a fraction of a Canadian RM's full scope. I work in a large shared-care practice with 12 family physicians and midwives, a model that significantly departs from the standard midwifery model of care in a creative effort to meet community needs. These atypical work arrangements, paired with my awareness that changes in research and practices often outpace my ability to keep up, sometimes leave me to question whether I can still truly consider myself a nurse or a midwife. The standard I use to legitimize my professional identity keeps shifting—it feels like a moving target. Lauren, your stories of working both within and beyond the traditional model, and your views on sustainability and nurse-midwife intrapartum collaboration have helped me to reconsider how I view midwifery work and my relationship to it. I am writing today to share some of those reflections.

During our conversations, you told me about your own path in midwifery and the very interesting directions you have chosen recently to create a sustainable work-life balance. I learned that after graduation, you began in a rather traditional model of Canadian midwifery care. You worked in a small and consistent midwifery team, caring for clients from pregnancy through postpartum and were on-call on a rotational basis for the needs of families you generally came to know well. You explained that in the province where you first practiced, *midwives are very siloed within hospitals*. I learned this means that midwives accompany clients into hospital and independently perform all admission, in-patient, and discharge care, without the assistance of nurses. I was curious about your perceptions of the interprofessional dynamics there. *The hospital I was at, the midwives talked a lot about what great relationships we had with the nurses—which was perhaps true. I was like, you know, they're not openly hostile to us. They*

accept that we're there. But it wasn't collaborative—but that also wasn't the standard and wasn't the expectation. This sounded reminiscent of the arrangement I knew as a new nurse in Alberta.

I found myself thinking hard as you described how you did not like *inhabiting both [nurse and midwife] roles at once* during hospital labour care. *Working as a midwife in Ontario, I felt like I was doing my old job as a [labour and delivery] nurse AND the work of the midwife with nobody to relieve me for break and never going home. It was terrible*. You reflected on managing labours requiring interventions such as an epidural or oxytocin (both of which you managed independently after physician consultation), sometimes for 24 hours with no system for break relief. You describe the difficulties with retaining a view for managing the case while *also really engaged in the minutia of doing all the other stuff.* I was struck by your words that seemed to serve as a confident summary to communicate role negotiation with nurses*: Come on in! I'd like you to do the heart rates and chart that, and do all your nursing tasks. And I will be the midwife.*

The way you described what it means to "be the midwife" in relation to your obstetrical nurse colleagues offered me valuable insight into how you view yourself. You spoke of the midwife as the one who has *the responsibility and that oversight of the big picture seeing, like, how is this person's labour progressing? And, what are we seeing with the assessments that my nursing colleague is doing? What is that showing us?* You added that part of your role is also *to provide support to the client as they need [...].* You told me that you *certainly don't mind doing some of the assessments through a person's labour that a physician, for example, would rarely do.* This includes *fetal heart rates and vitals and palpating contractions and all of those things, and hands-on labour support.* As you shared your reflections on nurse and midwife labour collaboration, I felt stirred by a mix of feelings and questions. And I noted in this last statement

that you compared yourself with a physician, something that does not naturally come to my own mind to do. The inpatient setting appears to be a particularly powerful site where the interfaces between nursing, midwifery, and medicine become active spaces of professional identity negotiation.

The arrangement you described with midwives working in hospital in isolation without nursing support is familiar to me. It reflects the model I have witnessed throughout my career in the two provinces I have worked. At the hospital where I've done all my registered midwifery practice, midwifery clients receive nursing support only in specific situations involving certain medical interventions. (I will note that nearly all local midwives have been advocating for equitable nursing support and the issue remains unresolved.) I did not share with you during our earlier conversations, but this evokes internal conflict for me. Over the course of working on my thesis, I have come to understand that the tension is closely tied to my own sense of myself as a dual registrant of nursing and midwifery. When you and I have talked, I have found it fascinating how differently this topic of nurses and midwives working together has played out in your experience.

As I've mentioned, I had always envisioned my midwifery practice as an extension of nursing, not as something separate. That contrast between us has stood out to me, particularly in our discussion about nursing support for midwives in the intrapartum setting. You bring the unique perspective of having worked long-term in both nursing and midwifery roles where one-to-one dedicated nursing support is the standard for all patients, regardless of provider. While I did not hear your thoughts on how care is negotiated and experienced by each participant, I understood that you view it positively. Once you moved into midwifery—especially after struggling in a setting where too much was expected of you—you were increasingly dedicated to

that model of support. You were pleased to return to one-to-one nursing for all patients when you came back to work at the site where you had worked as a new nurse.

After graduating from midwifery, I welcomed the freedom to care for my clients without routine nursing attention—even in cases where protocols permitted it. For example, although it was nursing's responsibility to complete all patient admissions for a time, I preferred to do this work myself. It felt essential to my knowledge of and connection with my client and their support people. It was not about a lack of "trust" in nursing colleagues—a word I've heard used in this discussion—but rather about presence. Completing the full spectrum of care felt integral to how I defined myself as a midwife.

During our discussions of this topic, you add a critical dose of reality to my internal debate that I cannot ignore. You are clear that the expectation *to do all of that all the time* is *too challenging*. Role clarity and collaboration are matters of sustainable and safe practice. You reflect that expecting midwives to assume the role of the intrapartum nurse *contributes to fatigue in a way that I think can potentially impair my judgment.* I relate to that honest appraisal. You add the practical observation that the model of midwifery care that we both and many others have worked in is so high in volume that it demands constant multitasking: labs, calls, charting, pages. You compare it to how *a physician might be managing when they're doing a call shift.* Although you notice that the frequent interruptions impact your *ability to kind of BE a midwife and be more present with people*, I also sense a pragmatic acceptance and adaptable view of your role from how you may have once viewed it. This further underscores your point that dedicated nursing support becomes essential for midwives to fulfill the demands of their job well.

As you describe the realities of your care model with its volume and shifting emphasis away from continuity, I sense an increased divergence between the identities of midwife and

nurse. In this context, the midwife begins to resemble a physician more, particularly in scope and pace. Knowing that your earliest aspirations in healthcare were to become a physician yourself and enjoy a sense of *professional practice*, I wonder whether your current experience feels increasingly aligned with those original visions.

To offer my personal experience as a contrast, I believe that had I moved to my current site prior to applying to study midwifery, I may never have become one. The unit culture and nursing role was much more closely aligned with the vision of care I had for myself compared with the hospital I had previously worked in. In this new setting, I had more nursing autonomy, witnessed fewer routine interventions, and perceived from staff a greater respect and knowledge of physiologic labour and birth. I felt empowered to take responsibility for patient safety in all its forms, education, labour support, and ongoing assessments. The patients' physicians popped in and out at intervals of hours to provide a higher level of care management (or if I called them for an identified problem needing a response outside of my knowledge or scope.) Then, I called them for delivery when I identified it was time. These changes all positively transformed my experience of myself as a specialized nurse.

Lauren, another valuable perspective you have offered me is introducing the subject of sustainability to my concept of midwifery identity. While I hold dear the tenet of being 'with woman', I agree that the relentless pursuit of this ideal is unsustainable—and perhaps not even desirable. We're both cognizant of the high attrition rate among Canadian midwives; many of your classmates have *quit* since graduation and so have mine. You remarked that after one or two children, *they just can't work in a traditional model anymore.* That was certainly the case for me. I recall that relationship with families was central to you from the onset of your interest in midwifery; however, maybe the traditional interpretation of 'with woman' is an ideal we can

hold more loosely. In practice, it seems we already do. Thank you for helping me more thoughtfully confront the reality that without a flexible and adaptive view of ourselves, midwifery identity faces a much larger crisis of potential professional collapse.

What I hear from your story are components of a hopeful reimagining of midwifery—one that embraces flexibility to support sustainable and farther-reaching ways of being and working. You now focus primarily on your passion of community-based postpartum midwifery which admittedly offers limited continuity, shortened opportunities for relationship building, and few occasions for informed choice as many decisions have already been made. Yet, you still clearly see the work as meaningful and valuable. *I value the work-life balance that this model provides me and it allows me to keep working as a midwife*. You've used billing codes creatively, and you're leading client-centered initiatives rooted in dignity and responsiveness that are outside the traditional service model. I felt energized hearing about the postpartum consultation program you developed, your involvement in a pregnancy loss project that contributes postpartum midwifery support, and your commitment to evaluating and improving care.

The other week a student told me she did not enjoy her clinical placement with the midwives who cover 12-hour labour and delivery unit shifts tending exclusively to patients unattached to standard community care. She told me, "It didn't feel like being a midwife." I recounted this to one of my dearest mentors who immediately pushed back: "There are many ways of being a midwife now. We need to let go of that old way of thinking. The model almost killed us. Think of what it did to our families." Reluctantly and with a tangible sense of grief, I agreed with her. When I allow myself to think critically about the rigidity of the original model of registered practice, it pains me to think of all the ways the profession has let many midwives

down. Without flexibility, only the practitioners with substantive endurance and well-being, and supports to maintain their other responsibilities can continue to practice.

When I asked you if you can "still locate yourself as a midwife through all your changes," you pointed to the value of your graduate education (the new and only midwifery graduate program in Canada) in helping you to appreciate *the kinds of benefits of midwifery that we have evidence about*. You shared, *I'm trying to consciously own a bit more the value of midwifery* and admitted that doing so takes work. I was moved by the story you told of being a midwifery student placed with an obstetrician who, on several occasions, acted in ways that were blatantly unsafe and unethical. I felt a shared sense of horror at the examples you gave, and profound compassion for the bind you were in as a vulnerable student. Reflecting on that experience, you offered that *remembering things like that really helped to show the value of midwifery I think—that you can provide care in a different way to, you know, get to know people and understand their context and what's important to them and their values, and treat people with respect.* While you acknowledge that *midwifery is not perfect and we have a lot of work to do too,* you are clear in your view that *our model is fundamentally different.* You emphasized its foundations as setting midwifery apart from the *patronizing medical model* where in *power structures* lead to people *receiving unsafe care*.

You reflected honestly that you *still find it challenging to feel like I am an equal professional to my physician colleagues*, and retain a feeling of being an *imposter*. I was inspired when you shared your goal to try to embody midwifery's value, and that engaging in *midwifery-focused literature* has helped you progress in this way. I relate to your experience of seeing colleagues and friends who have a deeper understanding and feel comfortable advocating that midwives are *not just another primary care provider to see this baby who has nobody else*;

rather, *there is value to the way that we work with families*. This clarity to champion the profession is a feature I endeavor to develop as well.

I want to sit with these thoughts awhile longer. More to follow before long.

Warmly,

Laura

Letter 4

Dear Lauren,

One particularly special feature of our time together for me was how you have guided me to consider professional identity on a broader platform than individual sense of self or relationally with colleagues. This new way of thinking has been a tremendous contribution to my understanding. You shared with me some themes of discussion in your own graduate program that link directly to professional identity: *it's kind of been recognized in our discussions that Canadian midwifery kind of needs to assert itself but also define who we are.* You agree with this sentiment. *I think that's true. I think we need to be a bit more assertive and a bit more confident in the care that we provide.* I was keen to hear more and appreciated that these are thoughts in progress. *I don't have a good definition in my mind about, you know, even what midwifery IS in our current context*. I hear that, Lauren, particularly as much midwifery care now takes place outside of the traditional model. I share your desire to be *really clear myself about what it means to be a Canadian midwife and the skills that we bring, and be ready to share those confidently with others. I don't feel like I'm totally there yet*. I wonder if opportunities to have these storied conversations reflecting our life experiences can help move us toward more clarity.

As we have progressed through stories of your current practice and were starting to consider Canadian midwifery in its larger context, I asked you again if you could feel into the oldest parts of you that became interested in midwifery. I wondered what you might articulate about your values of Canadian midwifery. You told me, *what comes to mind is a profession that's really grounded in, like, women's ancestral knowledge, kind of thing. Like skills that people have always had and knowledge that you can learn through study in an academic institution but also that you could learn in your community. And I think that's still true about midwifery but that was*

something that I kind of thought what midwifery would be. And something that actively worked to empower women—that felt important. Work that would bring women choice into a space where they hadn't always had choice or agency. I think of midwives as being a group that would take space from other professions that had space and power…which we've done to some extent but there's still more places and ways to move.

One of the unique features of your many contributions to my thinking on professional identity is the role of midwifery professional associations. I heard you think deeply, comparing and contrasting your experiences of the two you know from your work, *how they function and how they don't function*. Your questions include mandate and hiring practices, noting the value of midwives on staff rather than all lay employees in an association. You are frustrated with the state of our profession in British Columbia, concerned in part that the lack of leadership in your professional association is compounding challenges to midwifery formulating a clear vision of its professional identity in these changing times.

I noted your emphasis on the value of an expanded role for a professional association well beyond the administration of programs directly linked to the provincial service contract. I had no idea before you told me that one midwifery association in Canada (i.e. Ontario) develops and disseminates midwifery-specific clinical guidance and practice standards based on research produced within the association itself. You explained that as a student in that province, those clinical practice guidelines were the standard of midwifery care, whereas students graduating from the province where you currently work look to national obstetrical guidelines to inform their care planning. You stated that relying on obstetrical research *is a real departure from this body of midwifery knowledge that we have in Canada.* Because there are no midwifery-specific provincial documents produced by the Midwives Association of British Columbia or a different

midwifery body in this province, registrants may commonly rely on clinical guidance that falls outside a midwifery-oriented way of caring for families.

I listened with interest as you described the sense of *unity* between member midwives and Ontario's midwifery professional association you observed as a student and early-career midwife. *I really felt there was a lot of solidarity with the [Ontario Association of Midwives], and that they largely represented people's views.* You proceeded to make the connection to how midwives experience themselves as members of the profession: *I feel like they truly represent midwifery in a different way that really kind of solidifies professional identity. I think professional associations are really important for that.*

As you spoke about this topic, a lightbulb went off for me. I suddenly realized that I have been deeply invested in nursing professional practice in part because of the strong professional presence I experienced through my university education and in the two provinces where I've worked. Throughout my years in perinatal care, I have continued to notice the strong visibility of Canadian nursing professionalism: the presence of numerous university programs (including doctoral options), peer-reviewed academic journals, powerful unions advocating for the profession, and nursing associations that represent and connect nurses through widely circulated publications.

Midwifery, by contrast, felt different—far less numerous, relatively newly regulated, and often viewed with skepticism by the dominant medical community. My perspective was shaped significantly by the fact that my interest in midwifery began while it was early in its journey toward professionalization where I lived at the time. Later, when I moved to British Columbia to practice nursing while studying midwifery, the level of hostility from my nursing peers toward midwifery cast further doubt. I note the contrast to your own experience where midwives were

positively regarded and thoroughly integrated into the hospital setting. I gained the sense that you advanced from nursing to midwifery with more confidence in its position.

While speaking with you, Lauren, I realize that for the initial years of midwifery work, I felt I had actually lost a degree of my professionalism. I acknowledged this to you with a sense of self-consciousness as it did not feel good to believe or admit. I explained to you that, in fact, when announcing to others that I was becoming a midwife, I added "but I'll still be a nurse" as if to reassure myself and others that I will still be a professional. Your surprise at this struck me, and it illuminated how differently we may come to view a profession and ourselves within it, depending on the historical, political, and social forces that shape our lived experiences.

As I wrap up this final letter, we have now met twice more—meetings that helped me to fill in new areas from your life. Reflecting on our time, several words come to mind as highlights from the windows you've offered into your professional identity: flexibility, autonomy, self-preservation, future-thinking, commitment, and balance. Through our conversations, I've come to see you as someone with wide-ranging intellectual curiosity, a passion for learning, and a growing inclination toward leadership and innovation. Your willingness to engage with this research topic on both personal and intellectual levels has allowed me to explore, alongside you, the past and current forces that shape professional identity in a Canadian midwife who is also a nurse. Your thoughtful reflections have challenged and inspired me to consider new dimensions of identity, including sustainability and professional support structures as key elements of professionalism. I look forward to the ways our paths may cross again as our stories continue to evolve.

With affection and gratitude,

Laura

Chapter 8: Publication

Manuscript For Submission to: Qualitative Health Research

Wordcount: 8,000 words or less excluding the abstract, references, and acknowledgements.

Title: Narrative Inquiry into Experiences of Professional Identity-Making in Canadian Registered Midwives Who Have Also Worked as Maternal-Child Nurses.

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Abstract

Maternal-child nurses and midwives play essential roles in Canadian maternity care. They are university-educated through separate direct-entry programs and licensed through independent national processes. They work within distinct yet overlapping professional capacities from conception through birth and the postpartum months in a variety of community and institutional settings. This study is the first to inquire into the experiences of a minority group of practitioners educated in both Canadian nursing and midwifery. In this **narrative inquiry** study, four participants with both Canadian nursing and midwifery education and practice engaged in three to four conversations (40-90-minutes each) over three to four months. These conversations exploring their storied lives were recorded and transcribed. Co-constructed narrative accounts were subsequently developed collaboratively with each participant. Laying these narrative accounts metaphorically side by side, I looked for narrative threads. In these threads I explore how participants experience professional identity-making, shaped by multiple temporal, social, and environmental contexts. Two **resonant threads** were prominent: 1. Professional identity is a fluid, continually negotiated experience, and 2. Identity-making is shaped by historical and social tensions. Rather than aiming to generalize, the depth and detail of personal stories unfolding in a relational space of inquiry underscore the richness of individual lived experiences and invite new ways of understanding the identity-making of practitioners with backgrounds in both maternal-child nursing and midwifery.

Keywords

midwife, nurse, Canada, narrative inquiry, professional identity, dual registrant

Narrative Inquiry into Experiences of Professional Identity-Making in Canadian Registered Midwives Who Have Also Worked as Maternal-Child Nurses.

Maternal-child[9] nurses and midwives in Canada work within distinct yet overlapping professions from conception through postpartum in both community and institutional settings. Canadian midwifery follows a direct-entry education model. Some programs offer advanced placement for nurses, a recognition of their relevant knowledge and skill. Part of students and practitioners' progression intrinsically involves developing their professional identity. Professional identity pertains to how practitioners view themselves and their role shaped in part by values and beliefs that bring meaning. To our knowledge, no studies have explored the experiences of people with both Canadian nursing and midwifery backgrounds as they contend professional identity-making within their temporal, social, and environmental contexts.

Background

Nursing and Midwifery Histories in Canada

In contemporary maternal-child care in Canada, Registered Midwives (RM) and Registered Nurses (RN) fulfill important roles among a broader multidisciplinary care team including obstetricians and family physicians. European contact beginning in the 1600s and colonialism disrupted Indigenous systems of childbearing care by imposing settler homeland customs (Benoit et al., 2007). Care during childbirth occurred in homes and relied on lay midwives until medical acts and regulatory changes shifted childbirth authority to academically educated physicians (Biggs, 2024). Medicare's establishment in the 1960s, combined with nursing's increasing professionalization, created the conditions for structuring maternal-child

[9] In this paper, I use the term *maternal-child* to reflect the language most commonly used in Canadian practice and literature. However, I acknowledge the gendered assumptions embedded in this terminology and support efforts to adopt more inclusive language, such as *perinatal–child care* or *reproductive and child health*, that better reflect the diversity of those receiving and providing care.

nursing throughout a medicalized, hospital-based system. Maternal-child nurses emerged as both a response to physicians' demand for hospital-based assistance and nursing organizations' efforts to formalize this area of practice (Benoit & Carroll, 2005).

Maternal-child nursing has increasingly professionalized, supported by national certifications and professional associations in perinatal, neonatal, and pediatric nursing (Canadian Nurses Association, 2025). Today Canadian maternal-child nurses work primarily in hospital with specialized, often technology-driven roles (Marcellus, 2019), navigating pervasive risk discourses that emphasize expertise and legal vigilance (Kelly et al., 2023; Phillips, 1999). Maternal-child nurses enact their specialized scope and competencies through initial and ongoing assessments, urgent responses, patient support and education, and communication with the primary care provider and consultants. Particularly in rural and remote birthing settings, this may include "carry[ing] out multiple aspects of care that would be the purview of midwives in other jurisdictions" (Zimmer et al., 2025, p. 2) including labour management and assistance with delivery.

Though midwifery education, scope, and system integration vary globally, Canada's reintroduction of midwifery and its positioning relative to maternal-child nursing are unique. Canadian midwifery re-emerged starting in the 1960s through advocacy movements that called for demedicalised childbirth, family-centred care, and an alternative to the physician-nurse monopoly over maternity services (Kaufman, 1998; Relyea, 1992). Early modern Canadian midwives included a mix of informally taught; nurse-trained; and internationally educated practitioners (Benoit et al., 2007; Burtch, 1994; Kaufman, 1998). Midwifery regulation began in Ontario in 1994 and has since expanded nationwide (Canadian Association of Midwives, 2023a).

Despite its growth, significant regional differences in access and availability remain (Canadian Association of Midwives, 2023a).

Canadian RMs are autonomous primary healthcare providers (Canadian Association of Midwives, 2023b). Canada's adoption of direct-entry midwifery education (Butler et al., 2016), rather than requiring a nursing background, was both strategic and contested (Benoit et al., 2001). This approach aimed to establish midwifery as an autonomous primary care profession, free from the traditional physician-nurse hierarchy. Benoit et al. (2001) describe midwives' concern that "nursing education supports structural subordination to physicians and leads to a lack of decision-making power" (p. 140). Debates over education pathways, scope of practice, model of care, remuneration, and system integration reflected professional tensions, ideological differences toward childbirth, and distrust that homebirth could meet modern safety standards (Blais et al., 1994a, 1994b; Burtch, 1994; Dixon, 1987; Goodwin, 1997; Kornelsen, 2000). Across Canada, RMs and RNs frequently interface in maternal-child care settings, particularly in inpatient perinatal units, where coordination and cooperation remain essential to quality care (Behruzi et al., 2017; Canadian Nurses Association, 2011; MacDonald, 2019; Macdonald & Etowa, 2021; Munro et al., 2013; Zimmer, 2006).

Professional Identity

Since the early 20th century, disciplines including psychology, sociology, and education have contributed to professional identity theory. Erik Erikson's work on psychosocial development informs an ego-oriented view of professional identity as "an actualisation of one's morals, values and beliefs giving meaning to one's self and one's professional life" (Cornett et al., 2023, p. 590). Sociological theories emphasize how professionals navigate institutional, cultural, and social structures to develop a sense of self. From this view, collective professional

identity reflects one's relationship to a group and supports professionalization. Proponents of a poststructural approach assert that discourse (i.e. “language in use” (Zembylas, 2003, p. 591)) socially constructs the self which is embedded in sociocultural, ideological, and political contexts, and shaped by power relations. Here, identity is not fixed, but understood as a fundamentally dynamic process, neither progressing nor regressing yet *becoming* (Zembylas, 2003). Narrative perspectives view identity as evolving, internalized life stories shaped by context, place, and time (Chase, 2011; Clandinin & Connelly, 1999b). Clandinin and Connelly, (1999) describe identity as “stories to live by” (p. 94), through which individuals assert, revise, and socially negotiate their sense of self (Blix et al., 2019). Estefan et al. (2016) elaborate that “stories to live by” conceptualize identity as “experiential, as contextual, as embodied, as always in the making, and as shaped at the nexus of context and knowledge” (p. 16).

Nurse and Midwife Professional Identity in Literature

The breadth of academic interest in professional identity-making reflects its personal, social, and institutional importance (Cornett et al., 2023; Fitzgerald, 2020; Monrouxe, 2010). Recognizing its links to midwifery recruitment, retention, and care quality, Pezaro et al. (2025) surveyed 860 midwives and nurse-midwives across 102 countries to examine professional identity and explore how best to represent the profession publicly. In Québec, Canada, researchers responded to a provincial midwifery request to revisit features of professional identity that promote coherence in future practice (Gagnon & Lemay, 2025). Although some international studies have explored professional identity among dual-educated nurse-midwives using various qualitative methods (Caldas Nicácio et al., 2016; Jayathilake et al., 2016; Scoggin, 1996), to our knowledge, no research to date has examined practitioners dually educated and practiced in Canada.

Narrative studies on nursing and midwifery identity are limited. Mulcahy's (2006) master's thesis explores how New Zealand dual registrants navigated intertwined nurse-midwife identities amid legislative change that separated regulation of the two professions. Asamoah Ampofo's (2018) doctoral research in Ghana illustrates the ongoing, contextually grounded process of midwifery identity-making shaped by life experiences beyond formal training and suggests broader implications for education and research.

Research Puzzle

Narrative inquiry is guided by a research puzzle grounded in experience and shaped by personal curiosity (Clandinin & Connelly, 2000). My research puzzle arose from wondering how individuals with a hybrid background in maternal-child nursing and midwifery experience and make sense of both themselves and their practice in the Canadian context.

Methodology and Methods

Narrative inquiry provides a structure for exploring human experience and making meaning through participants' stories (Chase, 2011). Its multiple methodological commitments (Caine et al., 2013) emphasize relational ethics, co-composition of texts, and participant-researcher relationships, aligning well with the values of the studied population.

Recruitment and Sample

Following approval from the University of Victoria Human Research Ethics Board (REB #25-0547), four people were recruited via an electronic poster shared within the Canadian RM Facebook Group. Eligibility criteria included completion of both nursing and midwifery degrees in Canada and at least six months of practice in both midwifery and a maternal-child nursing area within Canada. The four participants were each educated and practised in geographically distinct regions. All were currently practising as midwives; one also retained an active nursing licence.

As relational qualitative research, narrative inquiry studies do not aim to generalize but rather engage deeply with fewer participants to explore experience in depth (Clandinin & Connelly, 2000; Clandinin, 2016).

Data Collection and Analysis

After providing written consent, participants shared their stories. Each was offered a $20 refreshments gift certificate and received a $30 honorarium per meeting. Participants selected pseudonyms. Between January and April 2025, I engaged four participants over three to four one-on-one conversations, each lasting 40 to 90 minutes. I welcomed the use of artifacts, including photos, and encouraged participants to share early experiences leading to nursing and midwifery, as well as memorable transitional moments. Conversations were transcribed verbatim, and field notes and personal reflections were taken. These materials formed the basis for collaboratively composing narrative accounts. I met with each participant twice more to negotiate content and style. Each account was written in a distinct form (i.e., memos; travelogue; diary entries; and letters) to reflect the relationship built with the individual participant. Once finalized, I laid the accounts metaphorically side by side to identify resonant threads. These threads, described by Clandinin (2016) as "echoes that reverberate across accounts" (p. 132), constitute the core of the analysis.

Meeting Participants

Kristen described herself as a *guardian of normal childbirth*[10]. Influenced since childhood by family stories of Dutch midwives, she became aware of efforts to legalize midwifery in her province and applied to Canada's first midwifery education program (MEP). Unsuccessful, she pursued doula training then nursing education, practical efforts to *get more*

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[10] All *italicized statements* are direct quotations of the participant. Words in italicized *ALL CAPS* are those that were emphasized by the participant within a statement.

experience. Ultimately, both felt too limiting. She reapplied to an MEP and was accepted. Kristen's accounts are marked by years resisting dominant, often coercive forces within obstetrical nursing to protect birthers' integrity and priorities. Shaped by what she witnessed and the birthing care she personally received, Kristen reflected on her commitment to autonomy and client choice: *perhaps what I offer is what I wish was offered to me.*

Joan shared her journey to nursing then midwifery through vivid stories of remote travel, personal growth, and cherished colleagues. Driven by a teenage dream of becoming a neonatal intensive care (NICU) nurse, she began nursing education where she sought every opportunity to explore maternal-child care. During the program, Joan was jolted by a professor's candid feedback on an assignment about childbirth medicalization: *"You're not in the right field.* […] *You should look into midwifery*." Several years into her nursing career, Joan entered an MEP. *I just LOVED the degree.* Inspired by midwifery's philosophy and values, she reflected, *I became very passionate about informed choice and language*, describing with empathy and diplomacy how her perspectives on maternal-child care began to change.

As a young adult, Sarah felt an internal pull to be and do *different* in life than her peers, a sentiment that may have laid the foundation for her interest in midwifery. Curious but unsure about birth work, she chose nursing as something *productive*, though the education proved anxiety-provoking. Repelled by medical-surgical nursing, Sarah was enthusiastic about maternity care and secured a perinatal RN position which she continued throughout midwifery school. I was struck by how her stress and self-doubt about patient care dissolved *immediately* upon midwifery graduation, suggesting that the education and role affirmed Sarah's abilities and anchored her autonomy. She explained, *I trust my ability to identify and intervene more than*

being afraid of everything. Sarah described herself as a very *chill* midwife who treasures the long-term relationships woven through her community and practice.

Lauren brought a unique inquisitiveness to our conversations, offering critical reflections on professional and sociopolitical forces shaping nursing and midwifery. During her undergraduate studies connected to feminism and social justice, a chance encounter sparked her sincere interest in Canadian midwifery. When Lauren's first application was denied, she pragmatically chose nursing, despite longstanding discomfort with its perceived subservience and limited autonomy. *I felt uneasy with nursing.* Hoping it might serve as a stepping stone to midwifery, she endured clinical experiences laden with patriarchy and hostility toward birthing women. Although she later found a more positive perinatal environment, once admitted to midwifery, Lauren left nursing for good. No longer identifying with nursing, Lauren actively works to articulate midwifery's distinct professional value, especially in relation to medicine. *I'm trying to consciously own a bit more the value of midwifery.*

Findings: Resonant Threads

In narrative inquiry, narrative threads are understood as discernible patterns or "particular plotlines that were threaded or woven over time and place through an individual's narrative account" (Clandinin, 2016, p. 132). Clandinin (2016) suggests laying each account metaphorically alongside the others to search for resonances (p. 132). Two narrative threads resonated across the four accounts: Professional identity is a fluid and continually negotiated experience across time, place and social context; and, identity-making is shaped by historical and social tensions.

Professional Identity is a Fluid, Continually Negotiated Experience

Across the four narrative accounts, I detected fluidity, or an ongoing re-authoring of self (Clandinin & Connelly, 2000) which I present here through the three-dimensional narrative inquiry space attending to place, time, and sociality (Clandinin, 2016).

Identity-Making Occurs Across Multiple Settings

In narrative inquiry, place is understood both literally and symbolically. Physical space where participants learned and worked influenced how they viewed themselves and how others perceived them. In clinical hospital spaces such as the operating room (OR) and labour unit, both Kristen and Joan shared moments when who they are as a 'nurse' was often called forth. For example, when it was time to insert the urinary catheter in the OR, a staff nurse remarked, "*Kristen gets it, she used to be a nurse"* and, *"Kristen can do that. She used to be a nurse. She's one of us still."* This stood out in part because midwives are also competent in catheterization, yet this clinical skill became a focal point upon which others centre Kristen's nurse identity.

Joan shared how colleague nurses on the birthing unit sometimes invoked her nursing background, even though she had never worked there in that capacity. *They say, "That's because you're a NURSE that you're doing this."* She recalled a moment when a nurse in the staff room asked *in front of everyone*, *"So Joan," quizzing me, she's like, "Where do you put your charts when you're done with them?"* Initially confused but pressed further, she replied, *"I file them where they go."* The nurse replied judgementally, *"Well, some of your COLLEAGUES."* From *complaints* Joan receives *from the nurses*, she infers that she takes responsibility for certain tasks in ways that midwife colleagues may not. Others chimed in, "*Well, SHE wouldn't do that. Joan wouldn't do that. She gets it—she's a nurse."*

Reflecting on work like refiling charts of keeping labour rooms tidy, Joan highlighted values of teamwork, conscientiousness, and safety, expressing uncertainty *if that's nursing or if that's just me*. She traced some traits to childhood, recalling her propensity for *discipline* and order as evidenced by her immaculate bedroom and participation in air cadets. Joan shared that she *was always on the relay team* which presented as a metaphor for her belief in contributing individual effort to support team success. *I really am BIG on team approach and I like helping people out. And I think it's part of just being a nurse—you care for someone. You have that caring.* Despite others' assumptions, Joan experiences herself nuancedly.

While most Canadian midwives provide hospital-based care, they typically spend the majority of their time in community settings, including client homes and clinics. Sarah described her introduction to out-of-hospital birth, where she experienced the freedoms and non-traditional approaches made possible by non-institutional environments. She recounted the novelty of witnessing her first labour managed at home: *And then we went on this hike in her backyard which was to the back of this rock face and forest, like Canadian Shield rocks. And [I remember] being like, "I did not sign up for this. Why is this happening? [laughs] We were like following her around while we were trying to kick her into labour, and I just remember feeling like, "Where am I? What is happening?" It was really funny.* As I took in the shifts this story carried, Sarah leaned on her hand and laughed warmly at the memory. *And then we went back [to the client's home] and had a baby! It was easy peasy.* Throughout her midwifery career, out-of-hospital settings constitute environments where Sarah thrives with confidence, including supporting clients who make choices outside the community standard.

Non-physical, situational environments include spaces where institutional expectations or regulatory structures influenced how participants experienced themselves. Sarah shared that

transitioning to registered midwifery practice during the chaotic early months of the COVID-19 pandemic disrupted her sense of legitimacy and contributed to a nebulous sense of self. *It was also kind of weird because we hadn't written our licensing exam because we weren't allowed to.* Unsettled, she questioned, *Is this real? I don't know.* There was no ceremony: *We didn't graduate. It just happened.* These feelings resolved once she was established in practice.

Kristen responded to situational environments while working concurrently as a nurse and midwife. Fearing she might be perceived as overstepping her nursing scope, Kristen would call the doctor in *probably sooner than they would have liked because I didn't want to accidentally catch a baby.* She described an unintended consequence when a doctor she called "too soon" got frustrated and cut an episiotomy. *I blamed myself for that because she wouldn't have cut an episiotomy if the doctor had been able to finish her clinic before she came over*. These examples illustrate ways in which identity fluidity is expressed across physical and figurative environments as participants' respond to constraints, expectations, and shifting professional boundaries.

Professional Identity-Making Over Time

Past and ongoing experiences as well as future aspirations shaped the dynamic nature of participants' professional identity-making. Lauren and Sarah were influenced from childhood by a nurse grandmother, a source I shared. Kristen's long-standing awareness of midwifery arose from family stories, including one about a Dutch midwife who rode up on a motorcycle to her grandparent's home wearing leather chaps to attend a birth. There was significant movement in how participants viewed themselves over time as they progressed through both nursing and midwifery education. Their stories expressed a sense of looking back on how they once were and recognizing an evolution toward who they are becoming.

Three participants—Sarah, Joan, and Kristen—moved between nursing and midwifery roles for several years, particularly during midwifery education and early practice. Over time, each began to integrate new ways of being a nurse influenced by their exposure to midwifery. While studying midwifery, Sarah recounts replacing 'patient' with 'client' in her nursing documentation, despite being teased by an obstetrical resident. Joan described how her growing knowledge reshaped her approach to decision-making with families. Kristen eventually found the arrangement of moving between RN and RM scopes and roles at the same institution *untenable* while raising a young family. She resigned from obstetrical nursing but retained her licence. Over time and life stages, Kristen has continued to draw on both designations, including in perinatal mental health projects connected to her midwifery work.

Lauren's relationship to being a dual-educated practitioner was unique among participants, as she left nursing entirely at the start of midwifery school. *I was very cognizant that it was my last nursing shift and maybe forever. At the time. I took a picture of myself actually—I got someone to take a picture of me on the unit. In my scrubs. Because I was like, This is it. I'm going to be a midwife now.* As her work evolved to include care models beyond traditional midwifery service delivery, Lauren compared her role to the workflow and positioning of physicians. This comparison revealed vulnerability: *I still find it challenging to feel like I am an equal professional to my physician colleagues*. She grapples with *imposter* feelings *and* found the transition from nursing's hierarchical structure to midwifery's autonomy challenging. Lauren reflected that ultimately the nurse is *not the person in charge.* In contrast, as a midwife *you have a lot more responsibility and you need to make more decisions. And so, for me, that was hard. That was hard to kind of really take on that responsibility and own that.* Over

time, Lauren became more comfortable assuming the authority expected of midwives and developed a stronger sense of professional integration.

Participants also offered forward-looking reflections on their place in the professions. Lauren and Joan expressed curiosity about leadership. Lauren revealed academic inclinations and spoke enthusiastically about professional associations as a way to strengthen midwifery's collective vision and cohesion. Joan contemplated a perinatal leadership role, but hesitated, questioning whether her empathy, or her allegiance to nursing, might be a limitation: *I SEE the perspective from both sides maybe too much***.** Kristen shared aspirations of practising midwifery (or perhaps nursing) in a remote northern community. These forward castings reflect the fluid nature of participants' professional identities as they imagine future roles.

The Influence of Social Relationships on Identity Fluidity

Considering sociality involves attending inward to personal conditions such as "feelings, hopes, desires, aesthetic reactions and moral dispositions" (Connelly & Clandinin, 2006, p. 480), and outward to social conditions (Clandinin & Connelly, 2000; Clandinin, 2016). When moving between her two roles on the same unit, Kristen recounted how she socially cued these shifts*: the OBs would just look at me and say, "Kristen, WHO are you today; are you a nurse or are you a midwife?" And I said, "If I am wearing scrubs, I am a nurse. If I'm wearing street clothes, I am a midwife."* Her response offered a practical shorthand for colleagues to recognize her scope and responsibilities, yet I wondered what internally accompanied this outward change. *I think that part of your identity as a nurse wearing scrubs really reflects how you've integrated yourself into that institution. And you're following their rules by wearing their uniform. And conversely, when you're— I don't know what it's like when you've been a midwife, — but wearing street clothes is something that I have always done to kind of help people realize that we're normalizing birth.*

As a midwife, Sarah negotiated her professional identity in direct relation to obstetrical nurses assigned to her labouring clients. At her previous site, per unit policy, Sarah provided all labour and postpartum care herself, calling in nurses only for delivery. At her current hospital, where 1:1 RN care is standard regardless of provider, she faces uncertainty: *it was kind of like, You're here now, I'm here, we're both here—what do we do?* When I asked if performing, tasks (e.g., fetal heart rates, maternal vital signs, repositioning) was important to her, Sarah replied bluntly: *Well, it's part of my JOB. So, I'm not delegating it for no reason just because [a nurse is] THERE. That's weird to me. It doesn't make sense to me.* She explored the roots of this tension: *I don't know if it's partly just because being from a nursing background that that's important to me or that's what I identify as what you should be doing as part of your job.* When negotiating roles in labour care, Sarah typically tells nurses, *I do a lot of stuff. You can fill in the gaps or I'll ask you to do what I need you to do, kind of thing*. Her account revealed underlying power dynamics influencing socially negotiated identity-making. *And I understand that the nurses feel like, but that's my job and I need to do stuff, but its MY client. I know them. It makes more sense for me to do the things.* These negotiations appear to strengthen Sarah's sense of herself as a midwife whose hospital-based work spans both professions.

Lauren's reflections offer a contrasting perspective. She described the challenge of managing labours with interventions such as epidural and oxytocin, often for many hours without relief, while maintaining clinical oversight and attending closely to hands-on care. Unlike Sarah, she asserted a clearer division of roles by summarizing her approach to nurse collaboration: *Come on in! I'd like you to do the heart rates and chart that, and do all your nursing tasks. And I will be the midwife.* Her statement raises questions about how perinatal nursing may be reduced to a set of discrete functions within nurse-midwife collaboration; and how the midwifery role

may be imagined as distinctly beyond them. Both examples illustrate how professional identities are relationally negotiated within inpatient environments shaped by beliefs about nursing, medicine, and midwifery.

Identity-Making Amidst Historical and Social Tensions

Participants' evolving identity stories emerged as deeply embedded within broader historical and social tensions. This section explores three subthreads that appear to shape dual practitioners' identity-making: the enduring impact of historical and social legacies; a feminist value-driven unease with nursing that informed participants' turn toward midwifery; and the conflicted position of privilege held by midwives who are also nurses, including bridging work they undertake in interprofessional contexts.

Negotiating Identity Across "Us" and "Them"

Kristen noted a phenomenon I have also observed: *midwives don't get as much respect as other healthcare providers who work in the hospital*. Joan reflected that, aside from a women's studies professor and one NICU nurse colleague, *my experience with midwifery from the nursing perspective […] was pretty negative to be honest from the nurses.* Tactfully, she searched for words. *It was never a positive… they didn't regard the midwives… it wasn't collegial. It was kind of like, THEM.* Joan lamented a local decline in collegiality, attributing it to new physicians from a region historically hostile to midwives and their expanding scope which encompasses care previously overseen by obstetricians. Lauren added nuance by emphasising the collegial atmosphere at her current site where midwifery is well integrated. However, she recalled adversarial attitudes during nursing school, including a perinatal nurse's lecture spreading misinformation about midwives, and RNs from Lauren's maternity placement *who proclaimed they were going to QUIT if midwives got privileges there*. Lauren's awareness of persisting

tensions surfaced in a passing remark about difficulty obtaining perinatal nursing employment after midwifery graduation: *I don't know if people saw that I had trained as a midwife and were like, no thanks. It was surprising actually how challenging it was [to get hired].*

A sense of uneasiness between nursing and midwifery professions surfaced in several stories about participants' transition into midwifery education and later into practice. Joan told me she was offered a second interview for a shortened MEP designed for applicants with a healthcare background. *I did this other interview where they were very much questioning what my motive was as a NURSE to become a midwife.* Kristen, who applied a few years earlier, elaborated, *Well, I recall when I was applying to [a Canadian] midwifery education program, I was told they will never—as a labour and delivery nurse, they will never let you in. Because nurses have preconceived ideas about how a birth should go and nurses just can't deviate from that.* Kristen was ultimately accepted, in part because the program chair had worked with her clinically and could vouch for her openness: *they realized, okay, we obviously can't make assumptions about all nurses here.* After graduation, Kristen sought employment, but there were no midwifery openings. She went to the nursing unit, *and I said, I'm a nurse and I'm a midwife and I want to work here.* They hired her as an obstetrical nurse, *and THAT was interesting in that they had assumptions about me that as a midwife, I was going to nurse in a certain way*.

Sarah experienced mixed impacts of her nursing background on the relationships she formed during midwifery clinical placements. *My nursing background really helped me in a lot of aspects but it also kind of sometimes hindered me just based on what midwives thought*. She found this striking *because it's always the other way around — How are we [as midwives] going to be perceived by the nurse and the OBs? but I felt like when I was in my first placement there was one midwife in particular who did not like me, didn't give me a chance because I was a*

nurse. She had decided I was going to be, like, too medical. These stories reflect the external pressures on identity formation shaped by historical and social legacies across time, place, and relationship.

Backhanded Privilege

Sarah, Kristen, and Joan each described the bind of being granted a privileged position by nurse and physician colleagues due to their nursing backgrounds. This recognition offered trust and access but also introduced challenges. Their stories reveal the identity work involved in navigating this backhanded privilege. Sarah described that in her region, confusion about midwifery is compounded by the presence of unregulated birth workers. This creates tension when underinformed staff project their judgments onto RMs. Yet Sarah feels somewhat shielded from criticism: *I feel that I have a weird kind of perception of it because I was ONE of them* [i.e. the hospital staff]. *Like, there is a lot of trust for me […].* She added, *There has always been that [belief] that, I don't know, sometimes the midwives do weird things and are kind of rogue.* Sarah emphasized that years of *having worked with people day in and day out* helped her preserve those interprofessional relationships as she transitioned into midwifery practice.

During our conversations, Kristen reflected on the impact of interdisciplinary colleagues' remarks that centre and celebrate her nurse identity while she is in her midwifery role. *It makes me feel a little bit revered. But it also helps me to notice that people, a lot of people, value my nursing knowledge much more than my midwifery knowledge. A lot of people still think midwives are complete flakes*. She actively protests this false belief by attending mock codes for neonatal resuscitation beside her physician and respiratory therapist colleagues. *I think I've very clearly shown my skill set there. And I always make sure that I introduce myself as a midwife at all of those.* Here, Kristen's deliberate assertion of her midwifery identity serves both as an education

strategy to defend and elevate the midwifery profession, and as a personal affirmation of her professional competence.

Joan reflected on the conflicted position she occupies when colleagues express greater regard for her than for other midwives because of her nursing background: *I have trust because I have nursing, right? There are remarks about that all the time which I feel bad [*about*] because I love my midwifery colleagues and I think they're all excellent.* This praise sits poorly with Joan. *I have a lot of respect from the people I work with, but I feel that it's unfair. It's complimentary to me but it pisses me off because I feel like they're kind of disrespecting my profession. I feel like the midwives who don't have nursing should have that [*respect*] as well.* Her story reveals the double-edged nature of professional proximity. The regard interprofessional staff afford Joan sharpens her sense of injustice over the marginalization faced by non-nurse midwives.

Lauren contrasted her experience at a hospital where she had no prior connection to staff with her return to a site where she had previously worked as a nurse. Reflecting on the former, Lauren noted, *The midwives talked a lot about what great relationships we had with the nurses—which was perhaps true. I was like, you know, they're not openly hostile to us. They accept that we're there. But it wasn't collaborative—but that also wasn't the standard and wasn't the expectation.* Returning to a familiar hospital smoothed her transition. *It was really helpful for me to come back to the community as a midwife and reintegrate into [*that hospital*]. The policies hadn't changed that much. I was very familiar with the institution. I knew a lot of the nurses who were in kind of leadership roles. And that was, I mean, as a new midwife in the community, like, that's such a gift.* Lauren describes having had *lot of trust from them right away* rooted in her previous nursing relationships, unlike most new midwives who earn it over time. Distinct from Joan's, Lauren's stories reveal positive aspects of collegial regard without emotional costs.

Turning Away from Nursing: Bumping Places that Reflect and Shape Identity

Each of the four participants expressed some unease with nursing, either before or during their education. Both Lauren and Kristen had applied to an MEP before pursuing nursing. Lauren was critical of many student nurse experiences, including patriarchal messaging *about how to phrase things to a doctor so HE would think it's HIS idea.* Her introduction to maternity care was especially *negative*. She believed in the value of continuous labour support but found *there wasn't leadership or culture to support that.* Instead, she was expected to follow her preceptor's lead by chatting at the nursing desk rather than being with patients. This culture made her question whether she belonged in perinatal nursing. *It confirmed all of my suspicions. And, you know, because it reinforced everything that I'd read about the hostility that the medical system and the violence that could be perpetrated on women's bodies. It confirmed those things.* She felt that she *didn't really fit in within nursing culture* and was concerned about lateral violence and the effects on *those who were a little bit different and didn't completely tow the line—I felt that would be me if I worked there.* These tensions eased somewhat when she was hired on a different obstetrical unit where expectations better aligned with her values. Despite similar job descriptions, the divergent institutional cultures shaped how Lauren experienced nursing and how she saw herself within it.

Kristen worked in several hospitals as an obstetrical nurse and often found herself at odds with the dominant nursing culture. While others observed patients remotely via centralized electronic fetal monitoring, Kristen stayed at the bedside, committed to being *with woman*. She protested the culture of nurses' unquestioning adherence to protocol without *applying common sense*. When I asked if she could recall nurse Kristen before becoming a midwife, she reflected, *I remember that she was also protecting people from obstetricians and sometimes other nurses.*

Yeah, or like, in her head, telling people, "Stop doing that," or "stop, stop (...),"—yeah, just thinking, "gosh don't, don't DO that TO that person." Unfortunately. Or witnessing, probably witnessing abuses as well and feeling powerless to do anything about it— except becoming an autonomous primary care provider and help other people to have the birth that they want without being told they have to push on their back, without being told they have to have an episiotomy, you have to have forceps. She noted that her own birth experiences, which did not go as she hoped, probably *very much affects how* she cares *for others as both a nurse and a midwife.* Kristen's identity as a protector, forged in the tensions of her nursing years, appears to be an enduring feature.

Sarah had been aware of midwifery before applying to nursing but was unsure about pursuing a birth-related career without firsthand experience. She found obstetrical nursing stressful, experiencing self-doubt and anxiety due to inadequate mentorship and the pressure of caring for patients according to providers' specific standards. Additionally, Sarah found the brevity of nursing relationships *disenchanting*. She elaborated: *That's the one thing about nursing that I hated was not knowing. And being such a key part of someone's life to be like, "Okay, bye!" And never... Or even when you're working a shift and then they don't have their baby, especially when you've had them all shift and not getting to see. Or just being like, I wonder what happened to them.* Together, participants' stories illustrate how tensions with nursing, shaped by institutional norms and personal values, led them to turn away from the profession to varying degrees.

Value-Driven Turn Toward Midwifery

Just as participants' unease with nursing revealed identity tensions, their turn toward midwifery offered windows into who they saw themselves becoming, guided in part by values

they sought to live out more fully. Kristen first experienced midwifery as an obstetrical nurse: *If a midwife couldn't get their backup on time, they would call a nurse to a birth. And I often was the one that they called in because they realized that our values aligned, and that's how I got to observe. I saw, wow, a woman doesn't have to push a baby out on her back? Wow, she can eat and drink in labour.* Inspired, Kristen began incorporating midwifery-informed practices into her nursing, which met resistance from physicians. She came to realize that lack of autonomy constrained her ability to align practice with her principles. *Maybe it was just a title that I needed or a hat, a different hat to be able to offer the kind of care I wanted to offer.* As a midwife, she described herself as *relaxed*, *easy-going*, *pretty liberal*, and deeply respectful of client autonomy and informed choice.

Lauren became fascinated by midwifery before applying to nursing, drawn to its alignment with her interests in social justice and feminism. *It felt like really important work*. Participant narratives express how deeply held values including autonomy, respect, continuity of care, and person-centeredness contributed to propelling their transitions toward midwifery. Sarah affirmed, *The midwifery model of care has always spoke to me way more than nursing,* explaining that while she *like[d] nursing enough, it just didn't feed my soul like midwifery does*. Joan echoed this, emphasizing her belief in *the care that midwifery provides*. She shared, *I really learned a lot going through midwifery. It was kind of an eye opener to how some things are just not right the way I was trained as a nurse.*

Joan's pull toward midwifery stirred inner conflict in reconciling her dual identity: *I was really encouraged by others to go into [midwifery] but then also I didn't quite expect it to lead me down the path of kind of questioning my identity as a nurse. […] I learned quite a few things when I went through for midwifery. I felt shame as a nurse that I've been practicing that way. But*

it also made me feel good that I was on the right side now. So yeah… and I love nursing too. The active push and pull between Joan's sense of self in relation to both professions over time stood out across her account. Participants' turn toward midwifery were not just a professional decision but a deeply personal, value-driven expression of their evolving identities.

Living Identity-Making

Sarah, Joan, and Lauren spoke to the challenges of working within the midwifery model of care, even as they remained committed to its core tenets. They deeply valued patient-centered care and informed choice, but the demands of continuity, especially the unpredictability and strain of being on call for long periods, created internal tensions. Adapting their practice models supported sustainability, but often at the cost of the deep and extended connections with families they had sought when leaving nursing.

While learning from preceptor midwives, Joan faced a stressful situation that challenged her earlier belief in the pre-legislation ideal of being continuously "with woman" (i.e., with the client) whenever needed. This experience led her to establish clear boundaries around sleep relief and personal time, even when it meant breaking from a purist interpretation of continuity. She expressed profound gratitude for the *sacrifices* of the founders of modern Canadian midwifery, while also believing that midwives today need not universally subscribe to the solo-care model that was once a defining norm. Aware of the high attrition rate among Canadian midwives (Stoll & Gallagher, 2019), Lauren also adjusted her practice to support *work-life balance* and career longevity. Working outside the traditional model, she uses billing codes creatively and leads innovative client-centred initiatives. She described her care as involving constant multitasking of labs, calls, charting, pages, and likened it to how a physician might manage a call shift. While

Lauren acknowledged that frequent interruptions impact her *ability to kind of BE a midwife and be more present with people*, she conveyed a pragmatic and adaptable view of herself.

The Work of a Bridge

At times, Kristen, Sarah, and Joan were compelled or called upon to serve as a bridge. Kristen remembered being approached by a respiratory therapist to start teaching the neonatal resuscitation program (NRP) to interdisciplinary hospital staff. She recounted, *"Kristen, it would be so cool if you were a nurse but you're also midwife and then you taught this to everybody, and everybody saw that midwives can be cool also." Also!? I'm like, Dave, do people not think that midwives are cool!? [laughs]. He was like, "Well, some people have feelings about you. See if you can bridge it." And I said, I'll try.*

Sarah, who continued nursing throughout her midwifery training, also acted as a bridge. *I remember when I first came and said, I wanna be a midwife and people were like… uh ok.* Sarah made a face to convey their suspicion, then chuckled. But remaining integrated throughout midwifery education, *not just like Sarah moved away to become a midwife and then never heard from again,* helped shift perspectives. *Because I would come home and OBs and OB residents would be like, "How's school?" and "What's going on?" kind of thing.* Thanks to continuing in both roles simultaneously, she reflected *I think a lot of people gained insight into what all was involved in becoming a midwife. Which I think was a good thing.*

Joan placed strong value on her collegial relationships and found herself navigating tensions between her nursing and medical peers and her evolving midwifery identity. Following midwifery graduation, she returned to a former unit for a short nursing contract and encountered skepticism among colleagues, particularly about out-of-hospital birth. *People could not believe that I had gone into midwifery and that I could possibly be going to homebirths*. In response to

what she felt were uneducated assumptions, Joan shared research and explained the equipment and safety protocols for planned homebirths. *I just gave them perspectives*. During this time, she sensed a shift: *I felt in the middle, like I had to defend myself a little bit for the choices I had made*. Although she maintained her close friendships with staff, she noticed discomfort. *Before I was part of a team and we were all working together and I had held all the same beliefs as them. Then once I trained and went back I think I made some people uncomfortable because I was outside of that system now.* Joan's bridgework was underscored by compassion: *So, I understand why. I understand it from both sides.*

Looking back, Joan admitted that staying in nursing would have been simpler: *I never had anyone question me as a nurse about what I do*. As a midwife, she constantly defends a profession still misunderstood despite three decades of regulation in her region. *I'm going from this really respected profession to one that—I wouldn't say it's not as respected but you are definitely going to have pools of people that will respect you in midwifery and some people that will NOT—or who have their preconceived notions about you as a midwife. Because I've seen that so much. I saw a lot of that as a nurse and then when I became [a midwife], I knew all those comments and just even people being like, "So do you go to homebirths now? Are you one of those?"* Amid this background of othering, I raise the possibility that a dual practitioner may not feel they belong to one profession, the other, or even both—but rather, to neither. A static view of professional identity-making might expect individuals to choose; however, these narratives show how identities are dynamically negotiated across and within professions.

Discussion

Ødegaard et al. (2024) note that "professional identity is often described as the keystone of professionalism" (p. 7). It is commonly understood as the way individuals view themselves

within their profession, shaped by their values, beliefs, experiences, motivations, and sense of occupational group belonging. Professional identity matters because it influences both personal fulfillment and the quality of care or service provided (Moorhead et al., 2025; Pezaro et al., 2025). Throughout this study, participants' narratives carried implicit questions of professional identity: "Who am I?" and "What defines me as a person educated and experienced both as a nurse and a midwife in Canada?" Drawing on Deweyan pragmatist and constructivist ontologies, narrative inquiry conceives identities as ever in the making, not a fixed, achievable endpoint (Clandinin & Connelly, 2000; Clandinin, 2016). Participants' stories demonstrate how identities form and reform in response to multiple contexts and through the living and telling of experiences (Clandinin, 2016).

The narratives of dually educated practitioners reflect the relative newness of professional midwifery in Canada and the challenges of integrating into a healthcare system not originally designed to include midwives. Participants made visible enduring historical tensions that affect their positioning among colleagues and influence how they view and assert their dynamic identities. All four began their healthcare career as nurses but came to recognize that nursing could not fully accommodate their shifting self-perceptions, priorities, and values. Their stories reveal identity negotiation as both internally felt and externally performed, often in response to how others perceived and treated them. While participants frequently drew on core Canadian midwifery values, such as continuity of care, informed choice, and patient-centredness to describe who they believed themselves to be, these alone did not fully capture the complexity of identity-making as lived in social and relational contexts. Their hybrid professional background provided a unique, embodied understanding of maternal-child nursing and

midwifery. This dual perspective afforded empathy and insight but also situated them in complex in-between spaces.

For dual practitioners, the close-contact interprofessional intrapartum setting emerged as a contested space where professional boundaries were frequently challenged. Participants described feeling generally at ease in their midwifery roles, until their actions were questioned or undermined, often in relation to obstetrical nurses. Negotiating over tasks or role boundaries became highly personal when contested. Some recounted subtle forms of boundary policing, where seemingly mundane interactions tested hierarchies and delineated roles. While region-specific documents (see, e.g., *Guidelines for RN's Collaborating with RM's in Caring for Patients at Island Health: Roles and Responsibilities for a Hospital Birth*, 2015; Midwives Association of British Columbia, 2019) attempt to ease these tensions by prescribing divisions of labour, such efforts address only what practitioners do, not who they believe they have been and who they are becoming.

Participants' stories illustrate how ongoing identity-making is shaped by the friction between who they have hoped to be and what their work demands of them. Connelly and Clandinin (1999a) offer that, "“Who am I?” and “Who are you?” are common identity queries, queries that imply a fixed identity as if somehow or other the answer to the question touched something rootlike at the core of the person's being" (p. 95). Professional archetypes such as "nurse" as "carer" (Jaastad et al., 2022; Watson, 2008) and "midwife" as "with woman" (Bradfield et al., 2018) reflect similarly static and often reductionist view of identity. Participants' stories highlight how personal and institutional values, as well as persistent structures of power and hierarchy, shape the negotiation of identity over time. Taken together, these insights invite a reimagining of professional identity not as a singular destination achieved

through education or role adoption, but as stories told and retold, lived and relived, unfolding over time, context, and relationship.

Conclusion

Practitioners with hybrid midwifery and maternal-child nursing backgrounds are both part of and other than the entrenched professional structures and hierarchies that predate their entry into them. The tensions in their stories suggest that their presence as dual practitioners calls attention to these historical asymmetries, requiring them to navigate ongoing uncertainty, particularly around professional legitimacy and allegiance. Legacy tensions surrounding midwifery's entry into the healthcare system appear to compel these practitioners to enact deliberate identity choices that reflect their political and relational attunement to their complex practice contexts. Rather than occupying attained or fixed identity positions, dual practitioners' stories pointed to sense of themselves and their work as fluid and continually negotiated over time, across shifting contexts, and within social relationships.

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Conflict of Interest

The authors declare no conflict of interest.

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Chapter 9: Contemplating the Significance of Identity-Making

Co-constructing narratives with four participants educated and practised both in Canadian midwifery and maternal-child nursing yielded new insights into professional identity-making as fluid and continually negotiated across time, setting, and social context amidst persisting historical tensions. Narrative inquiry prompts researchers to consider the significance of their work across three domains: personal, practical, and social (Clandinin & Caine, 2013). Personal significance invites reflection of how the researcher has been impacted by new understandings and questions. In this section, I revisit my narrative beginnings with new insights; explore changes in my view of research, ontology and epistemology; and consider how I might apply what I have learned to benefit perinatal care and my professional communities. Practical significance turns outward to imagine applications in education, practice, institutional or professional domains. Here, I consider how higher education and professional supports might foster positive identity-making in interprofessional perinatal settings. Social significance encompasses theoretical, social action, and policy justifications (Clandinin & Caine, 2013, p. 174). On this topic, I consider how nursing and midwifery in Canada are often positioned as conflicting professions despite their potential for meaningful collaboration (MacDonald, 2019; Macdonald & Etowa, 2021; Zimmer, 2006). Together, these three lenses illuminate the broader implications of this research for supporting practitioners' sense of themselves and their work; enhancing career longevity; and strengthening synergy within and across professions.

Personal Significance and Reconsidering my Narrative Beginnings

Lyngstad (2024) explain, "Bruner highlights that the narrative inquirer will, through listening to narratives, better understand the narrator's identity, and thereby also themselves" (p. 221). This statement resonates with me and indeed, I have derived a better personal

understanding from this research experience. In preparing this final chapter, I re-read my Narrative Beginnings, paragraphs I wrote prior to reviewing literature connected to my research puzzle or engaging with others who share a similar professional background. Enough time has now passed to allow me to adopt a different perspective which I note is accompanied by a new sense of softness. I re-read my personal narratives and feel within myself a fresh curiosity. Somehow my own stories now read differently.

As I read, I ask, what was I expressing about myself? I detect early values and sources of wonder that influenced my professional path. I see signs of layered struggle including moral distress and ambiguity in my professional allegiance shaped by both internal conflicts and my relational contexts. Across my account, I observe frequent shapeshifting, an effort to connect with a deeply held sense of right from wrong, while weighing which practices to hold and which to let go. I detect an awareness of the costs and gains associated with each choice depending on the setting and context. I see how I responded to social and institutional pressures that I had not been prepared to face, prioritizing my desire to reduce friction and avoid further division. I perceive these now as adaptive approaches that served dual purposes: to ease my discomfort and to manage professional tensions.

The stories comprising my narrative beginnings suggest a belief that flowing with the strongest current was the safest most effective route, though I had not expected to face this journey at all. Today, I wonder whether, if I had been prepared and supported, I might have taken alternate routes that allowed me to assert my resistance in ways I longed for but did not feel able to express because of the personal and professional costs. I revisit the stories I shared about inspiring mentors and pivotal moments that called me to dig deeper to reflect on how I wanted to be in my work. In these attempts, I now see how I respond and change, change and respond.

Above all, I detect the unstated question beneath my research puzzle: Was this supposed to be so hard, or is there something wrong with *me*?

Rereading my own stories offers me insights into professional identity-making. I see how time, place, and relationships acted upon my identity work, and how I responded to my contexts—at times pulled toward a sense of authenticity and other times responding to forces with different objectives. Identity-making appears to be a process that requires compromise. I see how I started my turn toward midwifery for reasons that were personal, painful, and inspiring. And I realize that my desire to negotiate the transition to a new profession privately was not achievable. Identity-making for those who are both midwives and nurses is, in fact, surprisingly public. Against my earlier hopes, it appears that becoming a midwife was political after all. I now understand identity-making as a process entangled with power structures, social expectations, and claims to professional legitimacy that predates those who now work within them, whether or not they have language to describe them.

As the researcher, I recognize that I was drawn to this study topic for deeply personal reasons. Clandinin (2016) states, "As we tell our stories and listen to participants tell their stories in the inquiry, we, as inquirers, need to pay close attention to who we are in the inquiry and to understand that we are part of the storied landscapes we are studying" (p. 24). Embracing this methodological commitment to self-reflexivity was a gift to my learning. The questions at the heart of my research puzzle were ones that had followed me in my professional life and remain present in what I witness around me. Learning about the identity experiences of others with similar background has been personally meaningful. At the same time, it raises a concern: perhaps it does not need to be so hard. Perhaps there is work to do to ease the paths for others. With the knowledge I have gained, I ask myself: Where do I locate my responsibility? My

agency? How can I contribute to learning and practice environments where identity negotiation is not treated as a threat, but recognized as a natural and valuable part of professional life? How might I use my new perspectives on identity-making to support students and colleagues along their deeply personal and professional journeys?

This project has reshaped how I understand truth and knowledge. When planning my master's thesis, I envisioned a quantitative research study that might yield a discrete 'nugget of truth'. Even after turning toward a qualitative project, I sought the largest sample size I could justify. There was comfort in the idea of searching for a stable, knowable reality, even though I would not have called myself a positivist. Yet, as I engaged more deeply with the concept of identity, I came to see narrative inquiry as ideally suited to exploring layered, contextual, lived experience. It offered a transformative way to enter the research world alongside the participants, to stay with their stories and my own, and to tease apart the threads of professional identity-making with their partnership. Through this process, I learned that even a small number of individual stories, told over time and in relationship, could illuminate broader forces in meaningful ways. My understanding of truth and knowledge has shifted toward valuing situated and storied senses of knowing—an evolution that has felt surprising and profoundly satisfying. I have learned to tolerate a higher degree of ambiguity, contradiction, and unresolved complexity. The richness of participants' stories taught me to loosen my grip on a determined search for certainty and coherence.

The primary personal significance of recognizing the fluid and negotiated nature of professional identity as someone with both nursing and midwifery background lies in understanding that the forces shaping my experiences, relationships, and work are larger than me. The sense of not having arrived at a settled endpoint as a dual practitioner is not a reflection

of shortcomings of failing to adapt, take hold, or break from the past. Rather, it reflects the normal fluidity of professional identity as it responds to deep-rooted historical tensions and structural forces within the healthcare system.

Practical Significance

Threads woven across participants' stories suggest that professional identity-making is often catalyzed in moments of tension or marginalization. As an alternative to this reactionary process, I wonder what becomes possible if midwives, nurses, and those who are both, were supported to explore identity in spaces that explicitly welcome ambiguity, embrace evolution, and affirm the dynamic complexity of professional becoming. The practical significance of this research ties to its potential to inform both midwifery and nursing education, as well as the development of professional supports for Canadian dual-educated midwives and their perinatal colleagues. These findings may also resonate with individuals who enter midwifery from other backgrounds including healthcare by offering insight into the broader processes of professional identity formation.

Education

This study points to the value of intentionally engaging with identity-making in both nursing and midwifery education, especially for learners who cross professional boundaries. As educators support students' growth in skills and competencies, they may benefit from re-examining their role in students' professional socialization. I caution against explicitly or implicitly promoting the notion that students will, over time, adopt or arrive at a fixed professional identity. Instead, educators might foster reflective spaces where students can explore their personal histories, evolving values, the sociohistorical positioning of their professions, and the institutional power structures that shape their sense of self as an emerging practitioner.

Rees and Monrouxe (2018) write about the importance of supporting positive professional identity formation in medicine for developing confidence, collaborative leadership, and wellbeing:

> As part of professionalism curricula, individuals should be encouraged to explore how their experiences interplay with their personal and professional identities, discussing any feelings of identity threats or dissonance. They should be encouraged and supported in speaking out when they feel their values are threatened, to uphold their professional identities without fear. We consider that such an identities curricula—interwoven through everyday teaching and learning activities and professionalism curricula—could be the compass aiding navigation through the thorny journey of identity formation. (p. 203)

Monrouxe (2010) reminds readers that for medical students to develop professional identity they may be required to adopt "a different world-view, different values and emotional orientations" (p.44). The author's description of the experience and impacts of "identity dissonance" in medical students (Monrouxe, 2010, p. 42) lead me to believe that these reflections also have meaningful relevance to education in midwifery and nursing.

Clandinin and Cave's (2008) work on creating pedagogical spaces for developing physicians' professional identity offers one example of how this might be approached. These researchers used parallel charts and dialogue groups with family medicine residents to engage narrative reflective practices to support doctor identity development. Similar approaches may help emerging perinatal practitioners with hybrid professional backgrounds to cultivate their own "professional story to live by" (Clandinin & Cave, 2008, p. 766). Educational programs that support such learners may enhance student development by adopting pedagogical strategies that normalize uncertainty and change as integral features of ongoing professional formation.

Education that nurtures this kind of reflexivity may offer broader benefits. In a Canadian study of student midwives, Neiterman et al. (2024) found that some learners developed interprofessional partnerships during clinical placements, at times testing and negotiating perceived boundaries. Their findings uncover the potential for redefining traditional professional boundaries during training, not just in practice. The authors suggest that "since students are still "learning the ropes" of their professions, they may be more amenable to shifting interprofessional terrains and becoming agents of change" (p. 6). I wonder what further benefits might come from students being explicitly prepared for the fluid and ongoing nature of professional identity formation, both their own and that of their colleagues. Perhaps this preparation would cultivate empathy and commitment to supporting one another's dynamic professional becoming, rather than reinforcing narrow definitions of what it is to be a registrant in a given field. Restrictive definitions can limit potential, especially when they collide with externally imposed expectations from other professions. Educational programs that thoughtfully address the complex work of professional becoming may better support students to thrive across roles and contexts, including in spaces in-between, and to support their colleagues in doing the same.

Practice-Based Supports & Power

A second area of practical significance involves reimagining how power might be experienced differently if practitioners were supported to attend to identity-making throughout their careers and within interprofessional practice contexts. Several Canadian hospitals and health regions have implemented collaboration guidelines between midwives and nurses (see, e.g., Island Health, 2015; Mercer, 2024; Midwives Association of British Columbia, 2019), to facilitate interprofessional function and reduce tensions. While these guidelines may provide

practical structural clarity to assist midwives and nurses to navigate the closeness of their roles (though to my knowledge, their effectiveness has not been formally studied), they do not address the central role of professional identity. Specifically, they overlook the significance of how we see ourselves and who we are becoming as our knowledge, skills, and scopes evolve, as our patients' needs shift, and as our professions continue to change.

This study points to a need for more nuanced support structures in workplaces, and perhaps more broadly to professional associations, that address not only scope and role clarity but also relational and identity-based complexities. What might become possible if we were to replace confining expectations like, "I think I should be this" and "I want you to be that" with more generative, open-ended curiosity: "Who am I? Who are you? Who are we?" and "What might each of us bring?" In perinatal environments, where power differentials persist alongside rich potential for synergy (Brydges et al., 2021; MacDonald, 2019; Macdonald & Etowa, 2021; Zimmer, 2006), supporting practitioners to explore and express how they experience themselves—and to extend that openness to their interprofessional colleagues—may foster more adaptive and mutually honouring forms of collaboration.

Social Significance

Although I had not set out with this focus in mind, power emerged as a recurring subtext in participants' identity stories. This raised new questions about how professional identity for dually educated practitioners and others is shaped by broader systems of power and hierarchy, and about the agency they hold as creators of change. Participants shared moments in which they contested or adapted to expectations placed on them, especially when their hybrid professional backgrounds did not align neatly with the contexts in which they worked. This undercurrent has made me curious about directions for further study, particularly through a feminist lens. A

feminist perspective may offer valuable insight into the historical marginalization of both nursing and midwifery within the medical establishment and into how resistance efforts have shaped each profession's journey toward effective coexistence. Additionally, an intersectional lens may further enrich understanding by foregrounding how histories, contexts, identities, and social locations intersect over time to shape professional becoming.

Gaps and Wonders

As I move toward closing this thesis project, I have reflected on the less-heard perspectives within this study. One area that remains underexplored is the impact of dual educated practitioners on maternal-child nurses. The education and career trajectories of the four recruited participants (each now practising as midwives who have largely or entirely departed from nursing), understandably oriented the narrative space toward midwifery. As a result, questions about professional nursing received less attention. I recognize the importance of further inquiry into the experiences of nurses, particularly within intrapartum settings, where interprofessional uncertainties are most pronounced. I wonder, how do nurses experience and negotiate collaboration with dual educated practitioners? How do these interactions shape their sense of professional role, value, and identity? Gaining insight into nursing perspectives may offer important clues about how midwifery's presence influences nurses' practice, sense of self, and even their decisions to remain in or leave their speciality.

Lastly, the patient and client has largely remained a silent figure in this study. However, the social significance of supporting authentic professional identity-making, and of addressing background social and historical tensions, extends meaningfully to those receiving care. It is well recognized that interprofessional conflict can negatively affect patient experiences and outcomes (Lewis, 2023; Xyrichis et al., 2025). This perspective broadens the implications of how

practitioners experience and express their professional identities, and how these expressions, in turn, impact patient care. When dual practitioners are supported to integrate and inhabit their dynamic professional identities without conflict or suppression, the result may be not only more satisfying professional lives, but also deeper, more sustaining relational approaches to patient care.

Conclusion

This narrative inquiry on professional identity-making among people who are both Canadian midwives and maternal-child nurses suggests that a dual professional background is not merely a matter of acquiring multiple credentials, nor is it accompanied by an achieved and final sense of professional self. Instead, practitioners appear to negotiate an evolving view of themselves over time, place, and relationship, shaped in part by the social and historical positioning of the two professions within Canada's unique context. Exploring this deeply personal topic has allowed me to both understand myself and my world in new ways. It has been a process by which I have contended my own professional identities in personally transformative ways, coming to view my journey into and through these two careers with a greater comfort for ambiguity and multiplicity.

At the same time, I move forward with new questions, particularly those connected to power disparities, the potential for improved integration, enhanced interprofessional cooperation, and the conditions under which practitioners might thrive within their own visions of professional self. I wonder what more dual RM-RN practitioners, and perhaps others who bridge distinct health professions, might teach us from their unique vantage point of knowing and experiencing from within two, at times tense though potentially synergistic, professions. Do they hold a transformative combination of experience and perspective?

I think back with curiosity to Joan who remarked, *Maybe I understand perhaps too much from both sides*. While such tension may be experienced as a barrier, it might also be reframed as a strength. What if practitioners were supported to believe that understanding, feeling, knowing, and living *both sides* is not a liability, but a potential attribute to leadership? What can be achieved when the in-between is not experienced as fraught, but as fertile ground for broader social and professional transformation? Insights from dual nurse and midwife practitioners not only deepen our understanding of professional identity but may help us better grasp interprofessional complexities that may ultimately affect the quality of patient care.

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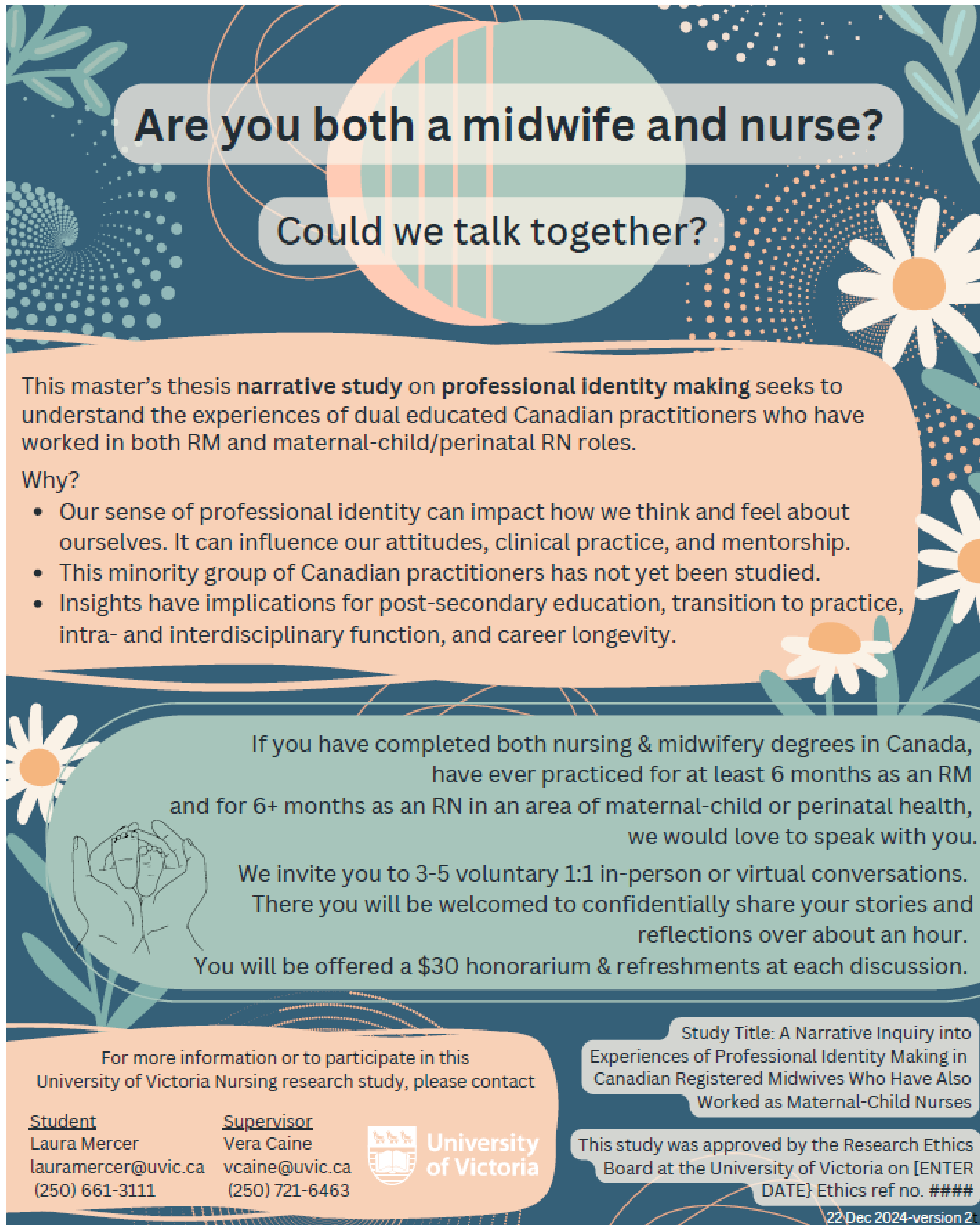
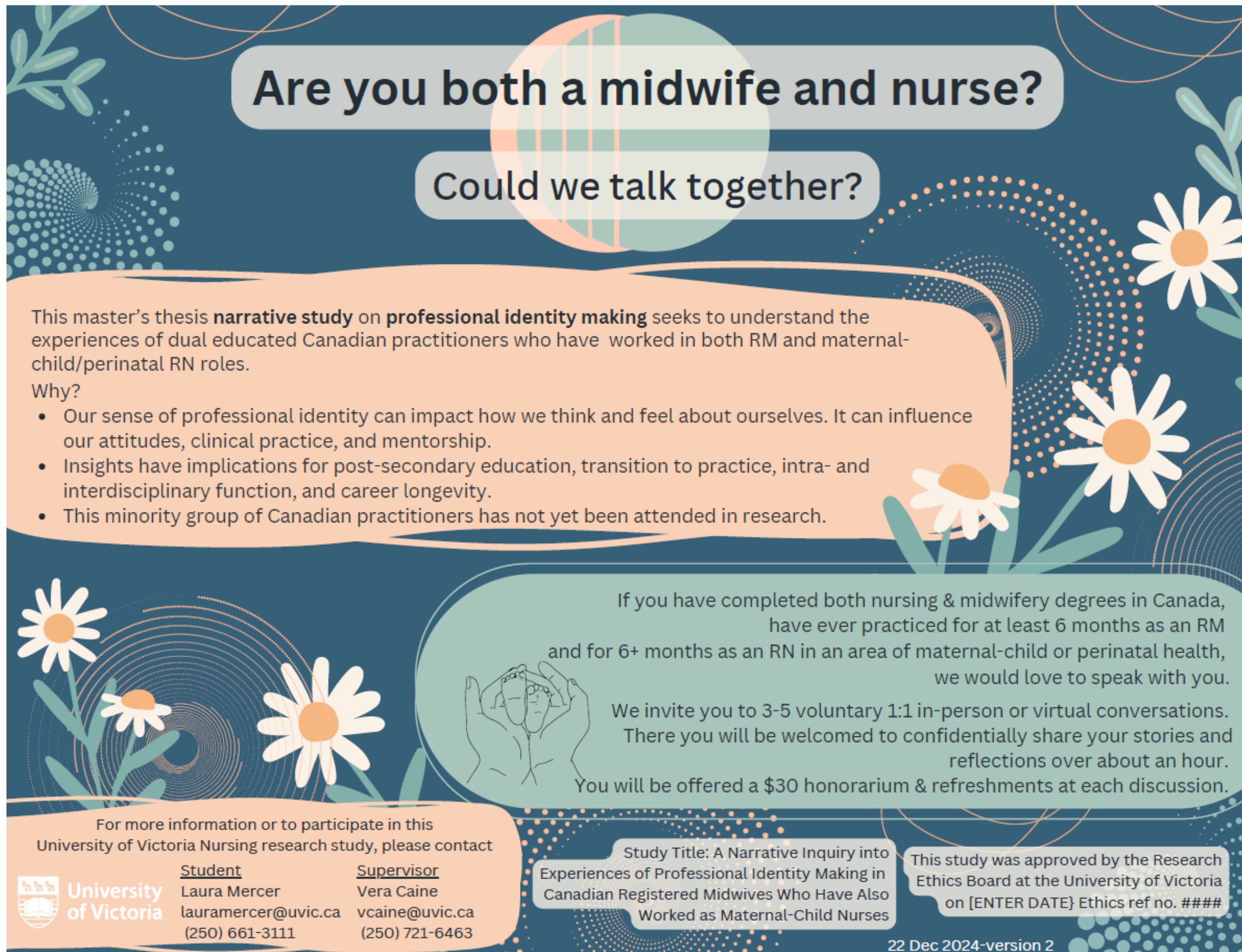
Appendix A Research Poster



Appendix B Research Postcard



Appendix C Guiding Questions

1. Tell me about how you came to nursing and midwifery.

2. I’d love to hear about your education and practice history.

3. What meaning has nursing had in your life? What about midwifery?

4. What beliefs do you hold about how others perceive your professional identity?

5. How do you express nurse in your life or work? What about midwife?

6. What makes you feel most like a midwife? A nurse?

7. Tell me about some challenges you have had in your work roles.

8. What do you imagine could have prevented some of those challenges?

Appendix D Ethics Approval

Office of Research Services | Human Research Ethics Board
Michael Williams Building Rm B202 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
T 250-472-4545 | F 250-721-8960 | uvic.ca/research | ethics@uvic.ca

Certificate of Approval

PRINCIPAL INVESTIGATOR:	**Vera Caine** (Supervisor)	**ETHICS PROTOCOL NUMBER:** Expedited review - delegated	**24-0547**
PRINCIPAL APPLICANT:	**Laura Mercer Master's student**	ORIGINAL APPROVAL DATE:	24-Dec-2024
UVIC DEPARTMENT:	**Nursing NURS**	APPROVED ON:	24-Dec-2024
		APPROVAL EXPIRY DATE:	23-Dec-2025

PROJECT TITLE: **A Narrative Inquiry into Experiences of Professional Identity Making in Canadian Registered Midwives Who Have Also Worked as Maternal-Child Nurses**

RESEARCH TEAM MEMBERS:
Evelyn Asamoah Ampofo - Supervisory Committee Member, University of Ghana

DECLARED PROJECT FUNDING: **None**

DOCUMENTS INCLUDED IN THIS APPROVAL:
Recruitment Approval Facebook groups x2.pdf - 24-Nov-2024
Newfoundland_Labrador Assocation Recruitment approval.pdf - 24-Nov-2024
Saskatchwan Assocation recruitment approval.pdf - 24-Nov-2024
MABC recruitment approval email.pdf - 24-Nov-2024
Nova Scotia association recruitment approval.pdf - 24-Nov-2024
tcps2-eptc2-certificate-MERCER.pdf - 24-Nov-2024
Guiding Questions and Prompts_26 Nov.pdf - 26-Nov-2024
Proposal Draft_Mercer_Nov 26_Full draft.pdf - 26-Nov-2024
Recruitment Postcard_version 2.pdf - 22-Dec-2024
Recruitment Poster_version 2.pdf - 22-Dec-2024
Consent form_Mercer_Version 2.pdf - 22-Dec-2024
Summary of Eligibility Criteria_Mercer_Version 1.pdf - 23-Dec-2024

Conditions of approval

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Amendments
To make changes to the approved research procedure in your study, please submit "Amendments" or "Annual renewal with amendments" form. You must receive research ethics approval before proceeding with your amended protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria's policies for research involving human participants.

Dr. Sandra Gibbons
Chair, Human Research Ethics Board

Dr. Cindy Holder
Vice-chair, Human Research Ethics Board

Certificate Issued On: 24-Dec-2024

Appendix E Information Letter and Consent Form

Information Letter and Consent Form

Ethics Study Number: 24-0547

Study Title:
A Narrative Inquiry into Experiences of Professional Identity Making in Canadian Registered Midwives Who Have Also Worked as Maternal-Child Nurses

Research Investigator:
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Phone: 250-721-6463

Background

You are being invited to participate in a research study entitled *A Narrative Inquiry into Experiences of Professional Identity Making in Canadian Registered Midwives Who Have Also Worked as Maternal-Child Nurses.* This study is conducted by Laura Mercer and supervised by Dr. Vera Caine from the School of Nursing at the University of Victoria. The results of this study will be used in support of my master's thesis.

Purpose

This study on the topic of professional identity aims to explore the stories of individuals who have both Canadian nursing and midwifery education as well as maternal-child/perinatal practice

experience in both professional roles. I am interested in understanding how Canadian practitioners' experience and navigate this combination of backgrounds across multiple contexts.

Study Procedures

If you choose to participate in this study, you will be asked to have audio-recorded conversations with me over a 2 to 3-month period. Each conversation is estimated to take about one hour. The conversations will be unscripted but facilitated with guiding questions inquiring about your history of learning and practising in both midwifery and nursing. We will meet virtually through videoconference or, if distance allows, we have the option of in-person meetings in public places. I hope to meet you once every one to two weeks for a total of three to five conversations. The conditions for meeting will be negotiated between us.

As a participant, you are welcome to talk freely about your past and current life experiences. All conversations will be audio-recorded and transcribed. I will invite you to share your stories through writing, art, photographs, or any artifacts that may help me better understand your perspectives. The focus is on creating reflective spaces that speak to your experiences. No artifacts will be included in any final research text. Any items shared will be returned to you during the conversations.

You are eligible to participate in the study if you:

1. Have completed both nursing and midwifery education in a Canadian institution
2. Have ever worked for at least 6 months in an area of maternal-child or perinatal nursing
3. Have ever worked for at least 6 months as a registered midwife in Canada

Benefits

You will be given an opportunity to tell your life stories within a safe relationship with the researcher. You might gain insights into how your midwifery and nursing dual education and practice present in your work and how this has shaped you. By telling your stories, you may become more aware of your life history, identity, beliefs, values, and strengths. You may also obtain a clearer understanding of how your life experiences are shaped by various familial, cultural, social, professional, and political backgrounds. However, it is important to note that there might be no direct benefit to you.

Payment or Renumeration

Participation for this study is voluntary; however, I will provide refreshments and you will receive a $30 honorarium at each conversation. Should you withdraw from the study, you may keep honoraria received.

Risk

As you tell your experiences of learning and working in these two professional roles, you may encounter memories and feelings which could be distressing or discouraging to you. Also, you

may perceive frustrations and limitations which you might find stressful. It is acceptable to express negative emotions during the conversations. If it is difficult for you, you are not obliged to tell me everything. You will be given a copy of the guiding questions in advance and may decline to answer any question at any time. In addition, you may choose at any time during any conversation to skip questions that may make you uncomfortable.

You have permission to take breaks from the conversations at any time and meetings may be rescheduled if necessary. I will offer frequent opportunity for debriefing difficult conversations, or help you to call someone you trust for support and stay in contact with you until they arrive. These conversations will take place outside of your regular work context to ensure you have time to be engaged and feel supported throughout this process. If unidentified issues surface during our conversations, I can direct and connect you to appropriate supports or resources without disclosing any of your information.

Voluntary Participation

Participation in this study is voluntary. Should you choose to participate in this study, note that you are under no obligations. Additionally, if you volunteer to be in this study, you may withdraw at any time up to the point before you give consent to the final narrative account. You may also refuse to answer any questions or talk about particular experiences. You can request to stop the audio-recording at any time. It is important to note that you will not be able to withdraw from this study once you review your narrative account. Narrative accounts will be analysed for narrative threads that resonate across the accounts. Removing one of the narratives will impact the soundness of the analysis.

Confidentiality & Anonymity

The information obtained in this study will be used in the writing of my master's thesis. It will also include various presentations or research papers. The findings of this research might also be shared to wider audiences through plain language reports, including brochures, or handouts. To avoid any personal identification, conversations will take place outside of your work context; the use of any particular names or places will be modified; and I will encourage you to choose your own pseudonym. I will refer to you in writing always by a pseudonym. You will also be able to remove any information from your narrative account. Before information is disseminated, I will share the narrative account, which reflects your story, with you.

Please note that for 5 years after the completion of the study, all the data will be stored securely within the University Systems secure storage that can only be accessed from on-campus and over the internet. My supervisors and I are the only ones who will have access to the original data. You can ask for a copy of reports or publications on research findings at any time.

Further Information

If you have any further questions regarding this study, please do not hesitate to contact Laura

Mercer at 250-661-3111 or lauramercer@uvic.ca.

The plan for this study has been reviewed for its adherence to ethical guidelines by the Research Ethics Board. If you have any concerns or questions regarding your right as a research participant, you may contact the Human Research Ethics Board at 250-472-4545 or ethics@uvic.ca.

Thank you for considering being a part of this research. I very much look forward to working with you.

Consent Statement

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form. I will receive a copy of this consent form after I sign it.

____ __________

Participant's Name (printed) and Signature Date

____ __________

Name (printed) and Signature of Person Obtaining Consent Date