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Midwife's Professional Identity in Gadamer's Hermeneutic Perspective

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Sector Group – Medical and Health Sciences

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Abstract

There is a genuine crisis in midwifery from which attention may be deflected by economic and political world events. Midwifery students are still taught that a midwife has four main professional senses or qualities in her professional work: hearing, sight, smell and most importantly, empathy. Can midwives still really use these senses however? We have international, state and local healthcare facility guidelines and a never-ending workload increase due to almost annual new 'optimisation actions' resulting from financial issues.

In guidelines and protocols, we do see changes. Since 2014, the criteria for the international guidelines for the professional activity of midwives have also changed significantly: the position of respectful care and the woman's choice as the determining factor in the healthcare process have increased in importance and been put at the centre of perinatal healthcare.

There have been many changes in healthcare philosophy in recent decades. The emphasis has shifted not only to thinking about safe healthcare, but also to respectful cooperation with the person cared for and to satisfaction with the healthcare services received. To date, despite these many changes, no research has been done into how Latvian midwives themselves see their professional identity and what basic values, norms and beliefs the concept of midwife's professional identity includes.

The aim of the Thesis is to gain an understanding of a midwife's perceived professional identity from Gadamer's hermeneutic perspective.

The objectives of the Thesis include exploring the concept of a practicing midwife's perceived professional identity and describing the core elements the concept of professional identity currently includes for practicing midwives.

The question of the Thesis is: how do practicing midwives perceive their professional identity?

Overall, in this research four main themes of midwives perceived professional identity with subthemes/intertwining elements were conceptualised:

1 The core elements of a midwife's professional identity

- love for humanity and belief in God / higher power and a woman's own ability and a midwife's ability 'to go with the flow';
- variation in the ability 'to go with the flow';
- courage and persistence;
- professional education and experience;
- practice of reflection and self-examination;

- changes in perspective after their own childbirth;
- ability to draw boundaries and attain professional/private life balance;
- look back at the Covid period and reflect on that period's values.
- As core hindrance, but regrettably constant element of midwife's professional identity nowadays, midwives noted overwork and struggles with finances.

The following three themes were conceptualised as elements which intertwine with the core elements of a practicing midwife's professional identity:

2 Working alongside changing attitudes towards childbirth

3 Communication

4 Legislation and practice

Conclusions

Considering all the narratives gained from these conversations with the midwives, the main message that emerges is the core elements of professional identity perceived by the midwives in connection with love for humanity, faith in God or a higher power and a sense of mission in this profession, which suggests that it is also a possible reason why, despite every hardship, midwives continue to work. It is also possible that some midwives avoid self-reflection to protect themselves from emotional distress and avoid acknowledging how difficult it really is. Thus they work, perceiving their work as a mission and a way of life and do not leave it in spite of the possibility of better pay and working conditions in another profession. This, in turn, does not allow them to insist loudly enough on their demands for midwives' rights to fully realise their professional potential and receive a decent salary. However, we must also take into account the fact that midwives are constantly overworked and struggle daily to earn a living, so they may no longer have the will or strength to fight for their rights.

Recommendations

One could simply start by reflecting on one's own professional performance and seeing what comes up. What could I start doing to promote the implementation of core elements of midwifery's professional identity in practice? There is need for open and creative attitude. Above all, it requires a willingness to take action and the ability to mutually agree and act proactively to improve the professional situation of midwives, rather than expecting someone else to miraculously resolve all the aforementioned issues.

Keywords: midwife, professional identity, values, beliefs, norms

Anotācija

Vecmātes profesionālā identitāte
Gadamera hermeneitiskā perspektīvā

Vecmātībā valda patiesa krīze, no kuras uzmanību var novērst ekonomiskie un politiskie notikumi pasaulē. Vecmāšu studējošiem joprojām māca, ka vecmātes profesionālajā darbā ir četras galvenās profesionālās maņas jeb īpašības: dzirde, redze, oža un galvenais – empātija. Tomēr vai vecmātes joprojām var tās izmantot ? Mums ir starptautiskas, valsts un vietējās veselības aprūpes iestāžu vadlīnijas un nemitīgs darba slodzes pieaugums, kas saistīts ar gandrīz ikgadējām jaunām "optimizācijas aktivitātēm", kas radušās finansiālu iemeslu dēļ. Vadlīnijās un protokolos mēs redzam izmaiņas. Kopš 2014. gada būtiski mainījušies arī vecmāšu profesionālās darbības starptautisko pamatnostādņu kritēriji: cieņpilnas aprūpes pozīcija un sievietes izvēle kā noteicošais faktors veselības aprūpes procesā ir kļuvuši nozīmīgi un izvirzīti perinatālās veselības aprūpes centrā.

Pēdējo desmitgadu laikā veselības aprūpes filozofijā ir notikušas daudzas izmaiņas. Uzsvērta ne tikai droša veselības aprūpe, bet arī cieņpilna sadarbība ar aprūpējamo personu un viņas apmierinātība par saņemtajiem veselības aprūpes pakalpojumiem. Līdz šim, neraugoties uz daudzām pārmaiņām, nav veikti pētījumi par to, kā Latvijas vecmātes pašas redz savu profesionālo identitāti un kādas pamatvērtības, normas un pārliecības šis jēdziens viņu skatījumā ietver.

Darba mērķis ir gūt izpratni par vecmātes uztverto profesionālo identitāti Gadamera hermeneitiskā skatījumā.

Darba uzdevumi ir: 1) pētīt kā praktizējošās vecmātes uztver savas profesionālās identitātes jēdzienu un 2) aprakstīt praktizējošo vecmāšu uztvertos galvenos profesionālās identitātes jēdzienus.

Darba jautājums ir, kā praktizējošās vecmātes uztver savu profesionālo identitāti?

Rezultāti

Kopumā šajā pētījumā tika konceptualizētas četras galvenās vecmāšu uztvertās profesionālās identitātes tēmas ar apakštēmām/caurvijošiem elementiem:

Vecmātes profesionālās identitātes pamatelementi

Sekojošās trīs tēmas tika konceptualizētas kā elementi, kas caurvij praktizējošas vecmātes profesionālās identitātes pamatelementus:

1) Darbs līdztekus attieksmes maiņai pret dzemdībām
2) Komunikācija
3) Tiesību akti un prakse

Secinājumi

Galvenais vēstījums, kas izriet no sarunām ar vecmātēm, ir profesionālās identitātes pamatelementi, ko vecmātes uztver saistībā ar cilvēkmīlestību, ticību Dievam vai augstākam spēkam un misijas apziņu šajā profesijā, kas liecina, ka tas ir arī iespējamais iemesls, kāpēc, neskatoties uz visām grūtībām, vecmātes turpina strādāt. Tāpat, iespējams, dažas vecmātes pašsaglabāšanās instinkta dēļ neveic pašrefleksiju, lai nevajadzētu veikt sāpīgas atziņas, cik patiesībā grūti. Tādējādi viņas strādā, uztverot savu darbu kā misiju un dzīvesveidu un neatstāj to, neskatoties uz iespēju iegūt labāku atalgojumu un darba apstākļus citā profesijā. Tas savukārt neļauj viņām pietiekami skaļi uzstāt par savām prasībām un vecmāšu tiesībām, lai pilnībā realizētu savu profesionālo potenciālu un saņemtu pienācīgu atalgojumu. Taču jārēķinās arī ar to, ka vecmātes ir nemitīgi pārslogotas un ikdienā cīnās par iztikas pelnīšanu, tāpēc iespējams viņām vairs nepietiek ne vēlēšanās, ne spēka šādai cīņai par savām tiesībām.

Rekomendācijas

Var vienkārši sākt ar pašrefleksiju par savu profesionālo sniegumu un redzēt, ko es kā indivīds varētu sākt darīt pats, lai veicinātu vecmātes profesionālās identitātes pamatelementu ieviešanu praksē? Ir nepieciešama atvērta un radoša attieksme. Visvairāk katrai vecmātei pašai ir nepieciešama vēlme kaut ko darīt un spēja savstarpēji vienoties un proaktīvi rīkoties, lai uzlabotu profesionālo darba vidi vecmātēm, negaidot, ka atnāks kāds cits atrisināt visus iepriekšminētos problēmjautājumus.

Atslēgvārdi: vecmāte, profesionālā identitāte, vērtības, uzskati/ticība, normas

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Abbreviations used in the Thesis

AI	Artificial intelligence
CTG	Continuous recording of foetal heart rate
GYNASOC	Latvian Association of Gynaecologists and Obstetricians
IVF	In vitro fertilisation
LMA	Latvian Midwives Association
MPI	Midwife's professional identity
NHS	National Health Service of Latvia
RSU	Rīga Stradiņš University
UK	United Kingdom
WHO	World Health Organisation

Introduction

When individuals sense that they are living through a period of crisis,
when foundations seem to be cracking and orthodoxies breaking up,
then a public space is created in which basic questions about
the human condition can be raised anew.
(Bernstein, 1983, 8)

Why am I doing this research?[1] I knew with my heart why I chose to do this research, but found it very difficult to explain or describe my reasoning until I came across the following words that explain it perfectly: "*Women in labour may be managed via monitors rather than physical assessment by a midwife, removing an awareness of the essential nature of the labouring experience and the human expression of that experience, and potentially de-skilling the midwife. Hermeneutic inquiry allows for investigation of the essential nature of human experience, of humans interacting with one another and with things. This focus on machination and commodification, that is, the replaceable human.*" (Dibley et al., 2020, Part I, Ch. II)

There is a genuine crisis in midwifery, as 1:1 care for women during the active labour period is still not provided, and even with the decrease in the number of births, it is not possible to provide it, because state healthcare institutions are experiencing one optimisation plan after another, from which attention may be deflected by economic and political world events. Midwifery students are still taught that a midwife has four main professional senses or qualities in her professional work: hearing, sight, smell and, most importantly, empathy. Can midwives still really use these senses however? We have international, state and local healthcare facility guidelines and a never-ending workload increase due to almost annual new 'optimisation actions' resulting from financial issues (Hansson et al., 2022). There is still no one-to-one care in birth units. This is not even likely in the very near future as the number of births continues to decline and maternity wards are constantly told that there is no more money and that they should optimise patient care wherever they can, thus promoting maximum standardisation of care processes and minimising staff involvement. This process is not something new; almost century ago Max Weber linked it to an *iron cage,* as administrative imperatives increasingly influenced the service relationship. He was distressed by the increasing rationalisation of contemporary life and viewed modernity as rooted in the rationalisation process. It was described in six principles:

1) *Principle of official jurisdictional areas* – fixed rules govern the range of official activities;

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[1] In qualitative design research papers, the tradition since the 1990s has been for the author to write about themselves in the first person rather than the third person.

2) *Principle of office hierarchy and of channels of appeal* which stipulate a clearly-established system of super- and subordination, with supervision of lower offices by higher ones;
3) *Principle of management of the modern office*, which is based on written documents (files), which are preserved in their original or draft form, and on a staff of subaltern officials and scribes of all sorts;
4) *Principle of education of officials,* which usually presupposes thorough training in a field of specialisation;
5) *Principle of full working capacity* – the maximum efficiency of modern bureaucracy stems from work time that is purely engaged with organisational, not personal, goals and commitments;
6) *Principle of general rules* – the management follows general rules which are more or less stable, more or less exhaustive and which can be learned; these rules apply regardless of circumstances.

In summary, it is practice that is subject to principle, rather than the other way around (Gubrium et al., 2016, 5–7; Maley, 2004). These tendencies are still evident in present-day healthcare services. What impact does this have on the professional beliefs, norms and values of midwives? We do see changes in guidelines and protocols. Since 2014, the criteria for the international guidelines for the professional activity of midwives have also changed significantly: the position of respectful care and the woman's choice as the determining factor in the healthcare process have increased in importance and been put at the centre of perinatal healthcare (WHO, 2018, 2022). Until this paradigm for the shift in perinatal care, the emphasis was on safety and accurate execution of medical manipulations. This is still required today, but with additional emphasis placed on a woman's freedom of choice and on respectful communication throughout the care process. In theory, professional identity and professional performance of midwives should also evolve in line with these guidelines over time. According to Gadamer, the prejudices of each individual, far more than his judgements, constitute the historical reality of his being (H. G. Gadamer, 2013, 289).

In 1990, Latvia declared its restoration of independence from the Soviet Union. In 2004, it became a Member State of the European Union. Latvia has therefore been an independent state for 34 years. Theoretically, the relationship between a woman and a midwife should also have changed, regardless of the state regime under which the midwife received her professional education. However, we must bear in mind the theories of personality development at different ages and stages and their influence on the personality throughout life (Gelman et al., 2007; Schwaba et al., 2018). To understand how different the midwives' educational and professional

development experiences are, even if only according to the educational system, we need to keep in mind the unique historical background of it. For example, that during the Soviet regime, the state was held responsible for its citisens and relationships at medical establishments, resulting in the relationship between any woman and midwife, as in any patient-healthcare provider relationship, being totally vertical (Chalmers, 2005; Pavin, 2007). Women were expected to listen to and obey their midwife, doctor or nurse without question. This meant:

- there was no notion of '*informed consent*'; women were supposed to do '*what their midwife/doctor or nurse said*' and it was unimaginable to ask for alternative options;
- there were no official policies about the oxytocin release mechanism in birth or women's basic psychological needs and it was a process guided strictly by medical professionals;
- no birth partners were allowed in any part of maternity hospitals; fathers and family members saw their child and partners for the first time after the birth and only when the woman was discharged from the maternity hospital. There were no mobile phones with which to chat to family. Not everybody even had a landline at home meaning that all communication with family members was by letter or restricted to a wave through the maternity hospital window;
- newborns were held separately from their mothers and were brought to them only for feeding according to a strict time schedule. From the 1990s changes could gradually be observed. The first change was the option that newborns could be left with their mother round the clock. This was seen as bold move and resulted in comments such as: 'How then could newborns be looked after if they were in the room with mother and not together all in one room with a nurse?"

Such changes were not limited to healthcare. People were forced to re-evaluate their entire value systems. The '*snowball*' effect in the field of information and the endless new, previously-unimaginable possibilities in different spheres had a huge knock-on effect on people's beliefs:

- after gaining independence, people were given the freedom and opportunity to read any information that interested them without fear of punishment. Previously, if it was discovered that you were reading or possessing so-called '*forbidden literature*' you could be even imprisoned for it, but this was no longer the case as such literature was no longer illegal or 'forbidden';
- people were allowed to make money, do business and make profit from it and were no longer imprisoned for doing so;
- the exponential growth in the field of information thanks to the internet and the seemingly endless new technological possibilities;

- the need to master the ability to distinguish between reliable sources of information;
- changing the priority foreign language from Russian to English in order to get the latest professional information;
- the change in the paradigm of professional competences, probably the most significant change of all; not all of competences that were learned while acquiring a profession were now relevant and it became necessary to continuously follow the latest research and guidelines, constantly being improved, changed and updated.

Parallel with the huge changes in society was the commensurate effect in perinatal healthcare:

- birth partners allowed in the birthing room;
- birth partners were now able to visit and even stay at the maternity home during the postpartum period;
- the advent of water births;
- home births, legalised in Latvia from 2007 (Regulations of Minister Cabinet of Latvia nr.611, 2024);
- freedom from alcoholic liquids for the treatment of the navel for a newborn;
- practical involvement and teaching of parents in new-born care from the first moments of life.

Changes were also made to the level of midwifery education; during Soviet times, midwives were only able to receive a secondary professional education. Following the political changes, it became possible to obtain a higher professional education, which involved a completely different approach to the study process. Studies no longer meant merely taking notes from lectures, but rather involved an active and independent search for information and the analysis of reliable sources. In addition to the scope of independent study work, the method of simulations was introduced and the form of classes changed from lectures with the lecturer in charge to discussions with a mutual exchange of ideas and simulation in a safe environment. The approach to practical lessons changed, with the emphasis shifting from performing correct manipulations to non-technical skills. Currently, the communication skills of future midwives are trained during every simulation. The very approach to skills training has changed: simulations take place in a safe environment where it is possible to learn from mistakes. This contrasts with the previous approach, where everything had to be demonstrated perfectly from the very first time.

To help midwives familiarise themselves with the latest trends in midwifery, and to help those not in possession of good English language skills, a national conference for midwives and nurses has been held annually since 2017 at Rīga Stradiņš University (RSU) in Latvia. The first main theme for midwives at the conference program was titled ‘A *woman’s basic needs during*

birth and the oxytocin release mechanism'. From the outset, it was ensured that it would also be possible to attend the event remotely and access the latest evidence-based information in Latvian. In addition, the Latvian Midwives Association (LMA) holds four conferences a year with the option of remote participation, ensuring that all LMA members have free access to the latest evidence-based information updates in midwifery in Latvian. All LMA conferences are also free of charge for midwifery students (LMA, 2024b; RSU, 2017; WHO, 2018). Further education events are regular and rich in evidence-based information, and the latest information is available to midwives with weaker English skills. Midwives have the opportunity to receive all this information in a convenient and understandable way. These changes should also lead to changes in midwives' professional beliefs, norms, values, and, indeed, their entire professional identity. The professional relationship between midwife and service user should have shifted from vertical to horizontal, yet no research has been conducted on this topic in Latvia so far. The question remains: have these relationships become horizontal?

Data on the exact number of practicing midwives in Latvia is currently unavailable. While there is a Register of Medical Practitioners of Latvia, which people can join after receiving the necessary education, this does not mean that they all are currently practicing. According to this register, the total number of registered midwives is 379 (see Table 1). However, only 219 midwives have registered with the LMA. The LMA is a non-governmental public organisation. It is a professional association of midwives that unites Latvian midwives. This is also an organisation that provides certification and recertification of midwives every five years. In order to obtain recertification, midwives must demonstrate the place and scope of their work in the previous period, as well as any continuing education activities. In Latvia, only certified midwives can work independently without being under the authority of another medical professional. Prior to initial certification, midwives work under the guidance of another certified midwife or gynaecologist. The LMA promotes the professional development and legal interests of midwives, as well as the prestige of the profession within society.

Table 1

Characteristics of Latvia

(Official statistics portal of Latvia, 2025; LMA, 2024a)

Population in Latvia	1 853 000
Children born in 2022	12 571
Current birth rate	9.37 births per 1000 people
Current infant mortality rate	2.7 to 2.8 deaths per 1000 live births
Current fertility rate	1.6 births per woman
Registered as medical practitioners - midwives	379
Number of Latvian Midwives Association members	219
Hours per shift for midwife at maternity hospital/maternity ward	12–24 h

The term ‘professional identity’ is widely used, but without a clear and unified definition of it. Fitzgerald’s concept analysis of professional identity in the healthcare field summarised the main themes of professional identity. This included actions and behaviours, knowledge and skills, values, beliefs, ethics, context of socialisation, group and personal identity (Fitzgerald, 2020). Gardner and Schulman describe the basic characteristics of professional identity as: a commitment to clients and society, a specialised and unique set of skills, the ability to make judgements, growing new bodies of knowledge based on experience, and a community of professionals who are able to guide and monitor themselves (Gardner & Shulman, 2005). Another suggestion for defining professional identity in healthcare describes it as the process of internalising the habits of thinking, feeling and acting, or as the process of internalising the basic values and beliefs of the profession, directly linking it to communication skills (Kalet et al., 2021). Communication is an essential part of a midwife’s daily work performance and part of every relationship with a woman, but sometimes professionals take it for granted. It is, however, an essential part of midwives’ daily lives and can make a huge contribution to their sense of well-being and value both as a human being and as a member of society. Sometimes, however, during busy periods, this essential communication falls by the wayside or is pushed aside. This can be, for example, because of the huge work load, which can lead to a lack of reflection and awareness of professional performance (Dykes, 2005). The difference between *professionalism* and *professional identity* can be defined by how professionals demonstrate their behaviours and attitudes (professionalism) and how they internalise the process of professional community norms, beliefs and values (professional identity). It must be remembered, however, that midwives, like any professionals, are human beings with their own personality and personal relationships with the surrounding world: “*In an era of hyper individualism, it is easily forgotten that we experience life in relationships. From the relations of family living and schooling to relations of work and retirement and the relations of sickness and care, relationships deploy ways of being and prompt directions for action. Relationships are ever present in life, mediating identities as much in the flow of interaction as in the personal monitoring of thought and feeling. Relation worlds and relation sequences – first parental, then educational, and later occupational – provide life with substance and pattering, giving shape to experience through time and space*” (Gubrium et al., 2016, 4). Demand for midwives providing excellent and woman/family-centred care is rising constantly and will continue to do so as demand for midwives’ professionalism in different areas also increases. A central theme in the study of the theories and concepts of midwifery knowledge is the midwife’s ability to be empathetic and to adapt to the individual needs of the woman and child, accepting them as they

are here and now, rather than expecting them to behave like convenient or well-behaved patients (Peters et al., 2020).

Summary of the Introduction

Midwifery students are still taught that a midwife has four main professional senses or qualities in her professional work: hearing, sight, smell and, essentially, empathy. Whether they are still able to use these senses is questionable due to international, state and local healthcare facility guidelines and a never-ending increase in workload from almost annual new optimisation actions due to financial issues. In guidelines and protocols, we do see changes. Since 2014, the criteria for the international guidelines on the professional activity of midwives have also changed significantly, placing greater emphasis on respectful perinatal healthcare and woman's choice as the determining factor in healthcare processes. In theory, according to current guidelines, the professional identity and performance of midwives should also change over time. Since 1990s, gradual changes have come about, including a higher level of professional education, independent management of the physiological perinatal period, home birth management and with them new possibilities in midwifery education and practice. All these changes should have meant that midwives' professional beliefs, norms, values and in fact their entire professional identity were also changing.

Aim of the Thesis

To gain an understanding of a midwife's perceived professional identity from Gadamer's hermeneutic perspective.

Objectives of the Thesis

The objectives of the Thesis include exploring the concept of a practicing midwife's perceived professional identity and describing the core elements the concept of professional identity currently includes for practicing midwives.

Question of the Thesis

How do practicing midwives perceive their professional identity?

Novelty of the Thesis

There have been many changes in healthcare philosophy in recent decades. The emphasis has shifted not only to thinking about safe healthcare, but also to respectful cooperation with the person cared for and to satisfaction with the healthcare services received. To date, despite these many changes, no research has been done into how Latvian midwives themselves see their professional identity and what basic values, norms and beliefs the concept

of professional identity of practicing midwives currently includes (WHO, 2018, 2021). How do these midwives perceive their professional identity today? It should be understood that currently midwives not only from different generations, but also those who were born, grew up and studied in different state systems and regimes, are currently working together as a team.

Although there are studies about women's and partners' perceptions of midwives' professional conduct, there are none about midwives' own perceptions of their professional identity and its core elements in Latvia. For the midwives who participated in this study, as well as for every midwife in Latvia, this would be the first opportunity to consider their own prejudices and those of their colleagues, as well as their professional identity and its core values, norms and beliefs. In addition to being a mutual discussion, it is hoped that this will encourage midwives to reflect on their professional identity. As society's demands and expectations grow, it is important that midwives are able to satisfy these demands while also recognising their professional limits. This will help them to maintain a balance between their professional and personal lives when taking care of others.

As the WHO stated in the document "Midwifery 2030", that Every woman and newborn should be cared for by a midwife, educated and trained to international standards, as midwives practicing as such standards could avert over 80 % of all maternal deaths, stillbirths, and neonatal deaths," (WHO, 2019, 11, 14). The results of this study could help stakeholders and midwives communicate in the future in a constructive and blameless manner, thus helping to provide the best possible maternity care while ensuring continuity of professional development according to latest guidelines and protocols.

1 Literature review

Aristotle's dictum: "All men by nature desire to know."
(Ormiston & Schrift, 1990b)

1.1 Search strategy and quality evaluation

The literature review was conducted as described in the methodology guide by Dibley and Dickerson, selecting and sorting research publications according to the previously set criteria:

- relevant keywords and research question/-s: *midwife's/midwives' professional identity, professional values, beliefs and norms; perception of midwife's/midwives' profession, midwife's profession, midwife's/midwives' attitude*;
- research conducted within the last decade (advisable);
- publications made in English (advisable) (Dibley et al., 2020, Part II, ch. 3).

Three main steps were conducted to maintain implementation of the methodology:

1 Initial search for relevant sources and exclusion of repeated duplicates, checking the obtained information by name and whether the obtained material corresponds to the topic of the work.

2 As part of the next step, the full text of the obtained source was evaluated and a decision made as to whether it could be included. The overall focus of the selected studies as well as its aims and objectives were reviewed. The appropriateness of the study titles and their relevance to this study was reviewed, examining the relevance of the study of midwives' self-perceived professional identity and its influencing factors. Research on midwives' self-reflected professional or professional identity norms, values and beliefs were included. Studies on the process of the formation and strengthening of the professional identity of both student and newly-independent midwives, and the factors influencing the development of that process, were also included.

3 The obtained data were verified by: relevance to the purpose of my research, year of publication, year of update, author, availability of full text.

Searches for literature were performed via the Primo search tool. Primo is in the joint catalogue of the RSU library and other libraries that have subscription and open-access, online databases, and the databases created by the RSU library. This contains resources such as Cochrane Library, ClinicalKey, DynaMed, UpTo Date, Science Direct, PubMed, The Boolean Machine, Karolinska Insitutet Library, Sage Journals, EBSCOhost, ProQuest, BMJJournals, Wiley Online Library, Web of Science, Scopus, ProQuest Ebook Central and McGrawHill

Access Medicine[2]. 689 full-text articles were found, including books. From theses, 372 duplicates were removed, 233 did not meet the necessary criteria and were therefore excluded. Work continued with the screening of 139 full-text articles, including books, from which those appropriate to this study aim were included in this literature review (See Figure 1.1).

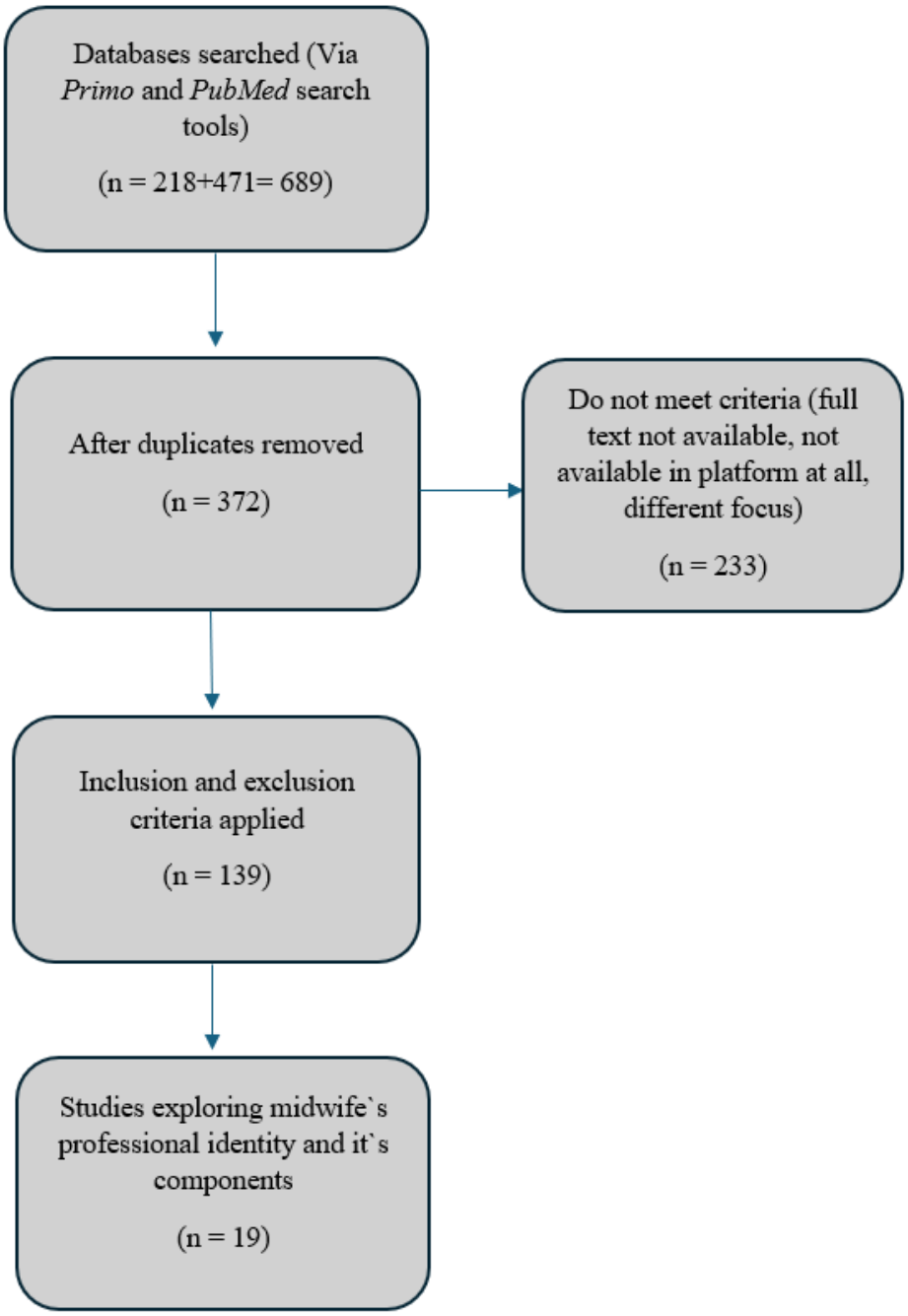

Figure 1.1 **Literature search and review model** (After Dilbey et al, 2022)

[2] Additional information about the electronic resources of Primo search tool and RSU library: https://www.rsu.lv/sites/default/files/imce/Bibliot%C4%93ka/datubazes-rsu-biblioteka-2024.pdf

1.2 Acquiring professional identity as a midwife

In the scientific literature the process of acquiring professional identity as a midwife is broadly discussed, in particular the challenges of this process, the impact of the characteristics of practice placements, the use of experienced midwives as role models and the contribution of practice mentors.

Aktas and Ilmaz (2024) researched Turkish midwifery students' perceptions of their experiences in a clinical learning environment and the positive effects of preceptors on the professional development of midwifery students. The study was based on the conclusion that clinical learning environments have a significant impact on students' acquisition of clinical competence and professional identity. The research was conducted with two data collection tools:

1 A brief survey designed to elicit student demographic information such as age, grade, practice status, clinical practice area and education model.
2 Midwifery Student Evaluation of Practice (MidSTEP) tool, to assess midwifery students' perceptions of their clinical learning experiences and the positive impact of academic/clinical preceptors on their professional development (Aktaş & Yilmaz, 2024).

A total of 205 volunteer students were included in the research sample. The results show that the majority of the of midwifery students in the present study scored positively on all sixteen items and at a high level on the Clinical Learning Environment Scale (Griffiths et al., 2020). Two standardised measurement tools were used in this research, which provided positively scored measurements. However, the study could have benefited from the addition of a qualitative research tool component in order to gather more profound and broader information about the midwifery students' views on the impact of the practice environment on the development of their professional identity.

Baird's research (Baird et al. (2023) showed that an extended placement in a midwifery group practice provides students with a rich, holistic learning experience, helping them to develop a sense of professional identity (Baird et al., 2022). The research explored the experience of midwifery students undertaking an extended placement in a midwifery group practice in Australia, partly to facilitate integrated learning. It was concluded that continuity of midwifery care benefits both childbearing women and the midwives themselves. This research used a qualitative, descriptive approach with four focus groups and the experiential method of thematic analysis. Four main themes were formulated:

1 Expectations of the placement;
2 Facilitating learning within a midwifery group practice model;
3 Transitioning between models of care;
4 Workplace culture of midwifery caseload practice.

Most participants agreed that this kind of practice placement was the highlight of their three-year programme and not as demanding as they had anticipated. All students reported feeling welcome when they started the placement. The continuity of care was something they all appreciated. However, students characterised transitioning back into the hospital's shift-based and rotation system as difficult. In terms of its impact on the development of their professional identity, this kind of practice placement was characterised as a 'safe space', supporting both their developing sense of self and confidence as senior midwifery students.

Similar research in other practice settings would be beneficial for midwifery programme developers and providers, enabling them to provide the best possible conditions for midwifery students to develop their own professional identity (Baird et al., 2022).

Bukkfalvi-Cadotte (2020) explored the professional identity of student midwives in Lithuania. Semi-directed interviews were conducted using a qualitative methodology with an inductive approach. All themes were grouped into two categories: themes related to a biomedical approach and those related to a holistic approach. The results suggest that the participating midwife's professional identities are particularly rooted in the biomedical world, however: "The ideas expressed by the participants can thus reflect larger tendencies in interprofessional dynamics in the field of maternal healthcare, revealing how different professional groups define themselves and relate to one another" (Bukkfalvi-Cadotte, 2020). Participants frequently associated midwifery and childbirth with the hospital setting rather than that of a private home. In the group relating to a holistic approach, the participants also described a holistic, woman-centred perspective. They distinguished their practice from that of other medical professionals by emphasising their unique perspective on pregnancy and childbirth, as well as their role in providing emotional support to midwifery students. The themes explored in this care work are very important in the professional identity of student midwives.

Researchers themselves noted that it would be beneficial for the representative of these findings to do further research.

In an interpretative, phenomenological approach study, Hadjittor (Hadjittor et al., 2022), using social identity theory, increased understanding of the relevance of professional identity and how this might further maintain the disgust taboo among nursing and midwifery students. The authors noted: "Although disgust is recognised as a common and prominent emotion in healthcare, little is known about how healthcare professionals understand, experience and conceptualise disgust. The aim of the study was to gain an in-depth understanding of how nursing and midwifery students experience, understand and cope with disgust in their clinical work" (Hadjittofi et al., 2022). In the introduction, the authors explore the fact that despite

spending a lot of time working in environments inundated with situations that could elicit physical disgust, healthcare professionals have to fight against their natural avoidance response and use a range of strategies in order to behave professionally. Four main themes emerged from their findings:

1 we are not supposed to express disgust as professionals;
2 we have ways of managing disgust;
3 it's easier to talk about moral disgust;
4 we respond to moral disgust by distancing ourselves from 'them'.

In the discussion section, the authors noted that the experience of disgust by healthcare professionals is greatly under-researched. This discussion makes a unique contribution to the literature within the context of the professional identity of nurses and midwives. They also noted significantly that: "These findings also contribute knowledge to our understanding of emotion management in healthcare by showing that disgust can be an additional, yet silent, cognitive burden for participants, which interferes with empathic abilities," (Hadjittofi et al., 2022). The concept of empathy appears in almost every current nursing or midwifery theory and is one of the cornerstones of the identity of both professions. The authors rightfully noted that the findings of this research might help in considering how training courses and healthcare foundations and services might be able to provide a safe space for professionals to address, discuss and normalise disgust.

In 2022, research was conducted in China regarding the occupational self-efficacy and ego-identity of midwifery students. The aim was to analyse the correlation between these two characteristics and to explore the factors influencing their occupational self-efficacy. The study used a cross-sectional survey with demographic questionnaire, a career self-efficacy questionnaire, and an ego-identity status questionnaire. A total of 232 midwifery students participated in the study. The authors noted that "the stronger the ego-identity of students, the stronger their professional identities will be" (Li, 2022). The authors concluded in their discussion that the results of the study suggest that undergraduate midwifery education is weak in terms of introducing students to the profession and providing career guidance. Several proposals for improvements were made:

- Schools should provide courses related to career planning;
- These courses should encourage students to think positively and evaluate the specific nature of the midwifery profession, including its professional values, beliefs and attitudes;
- School management should plan to conduct career-counselling and skills-development training.

As the study participants' answers were graded, grading their career self-efficacy and ego-identity status, this research theme could benefit from additional qualitative research tools to determine the possible reasons for midwifery students' low self-grading.

Mcluckie and Kuipers (2024) conducted an adapted critical discourse analysis of discursive constructions of student midwives' professional identities in the United Kingdom (UK). In their introduction, the authors highlighted that recent reports paint a dire picture of the poor quality of maternity services in some parts of the UK: "While this picture is not representative of all maternity services in the UK or internationally, it makes for sobering reading. The salience of this in relation to professional identity is highly significant, as aspects of autonomy, confidence, competence, responsibility, accountability, and embodied selves are implicated in the findings of adverse event investigations in UK maternity services" (Mcluckie & Kuipers, 2024). Critical discourse analysis employed to explore how regulatory policies construct student midwives' professional identities and create preferred 'subject positions' for midwives to adopt, and the impact this has on professional learning and practice. The findings showed that midwifery education and practice discourses are related to socio-political and historical contexts. The authors concluded that in standards midwives embody many qualities in their role and function. This leads to the construction of an 'imaginary autonomy'; becoming a midwife is more automatic (with the perception of control), than agentic.

Grounded theory approach was used to examine how 31 Canadian student midwives learnt to navigate and negotiate interprofessional boundaries in their clinical placements. Authors noted: "The literature on professional socialisation focuses on how students adopt and internalise professional identities and values and assumes that boundary work is essential to learning how best to practice their profession. However, a focus on boundary work in the context of midwifery training – which is embedded in the gendered and hierarchical landscape of maternity care – is lacking," (Neiterman et al., 2024). In findings most of the student midwives described several interactions with other healthcare professionals during their clinical placements. The participants' experiences showed a wide range of views about other healthcare providers, ranging from *"great"* to *"less than supportive"* and even" felt *attacked"*. Participants noted that in general they had a relatively clear understanding of the obstetrician- midwife and midwife-family physician relationship. At the same time, interactions with nurses were often described as creating considerable ambiguities. Authors themselves noted that this kind of research could benefit from a larger sample size or the use of participants from different locations. Nevertheless, these findings offer important contributions to the sociological literature on boundary work, showing how professional boundaries are navigated and negotiated in the context of a gendered and hierarchical healthcare landscape.

In the Netherlands and Iceland, a descriptive, qualitative study was conducted by Nieuwenhuijze (Nieuwenhuijze et al., 2019) to explore how Dutch and Icelandic midwifery students identify role models in contemporary midwifery education. As a focus instrument, group and individual interviews were used. Necessity for this kind of research is based on the fact that the dynamics of maternity care challenge midwifery and education programs, which need to keep up to date. In the findings of the study, four main themes emerged:

- opening up the scope of midwifery practice;
- creating an ideal role model;
- learning by observing, listening and doing;
- becoming a good midwife.

Authors concluded that: "Midwives as role models contribute to the development of students' skills, attitudes, behaviours, identity as midwife and trust in physiological childbirth. More explicit and critical attention to how and what students learn from role models can enrich the education program" (Nieuwenhuijze et al., 2020). They advised midwifery education providers to pay more explicit and critical attention to how and what students learn from role models, as this could enrich the education programme and support the development of the student midwife's philosophy of midwifery and its practice.

A descriptive, qualitative study was conducted by Mbalinda et al. (2024) to assess the understanding of professional identity and the barriers to developing professional identity among nursing and midwifery students and recent graduates from midwifery and nursing programs in Uganda. The participants were from nursing and midwifery and comprised 33 students and 26 recent graduates. The authors emphasised that a strong professional identity is the cornerstone of nursing and midwifery in a changing healthcare system: "Illuminating the complexities of nurses' professional identities amidst the rapid changes in healthcare, such as the digitalisation of healthcare and advancing patient care models, calls for a critical examination of nurses' and midwives' understanding of their professional identity so that their unique contribution to healthcare improvement is recognised" (Mbalinda et al., 2024). Themes that emerged were:

- understanding of professional identity in nursing;
- principles, characteristics and values;
- competencies;
- ethics and code of conduct;
- sense of belonging;
- barriers to professional identity formation;
- nursing educators/faculty not working in a clinical area;

- inadequate clinical mentoring;
- high workload;
- lack of policy implementation;
- many levels of nursing and midwifery practice;
- lack of clear scope of practice for each level of nursing and midwifery;
- low esteem amongst nurses and midwives;
- lack of policy implementation.

The authors concluded that most of the participants perceived characteristics and values, ethics and a code of conduct to be very important within the concept of professional identity. In this study student nurses / midwives expressed how their professional identity was impacted by intra- and inter-professional teamwork. Most of the other professionals did not understand the roles of other levels of nursing and midwifery practice. This led to situations in healthcare facilities where study participants were asked to perform functions that were not commensurate with their level. Authors noted that there is need to enhance leadership of clinical mentoring in order to enhance development of professional identity among students.

A multi cross-sectional design study was conducted by Wang (Wang et al., 2022) to assess the humanistic caring ability of midwifery students in China and to investigate its associated factors. 190 midwifery students conducted a multiple regression analysis based on the rule of thumb that at least 10 participants were necessary for each independent variable. The study highlighted the fact that nurturing humanistic caring ability is of great importance in midwifery education because healthcare professionals with desirable humanistic caring abilities are more likely to report high levels of professional satisfaction, commitment and fulfilment. Results showed that the humanistic caring ability of Chinese midwifery students was poor. Authors concluded: “Midwifery students in China have poor humanistic caring ability, which needs to be further improved. Interventions that cultivate the empathy, resilience and professional identity have the potential to advance the humanistic caring ability of midwifery students. Promoting a supportive and caring atmosphere among peers is also important,” (Wang et al., 2022). The authors also emphasised the urgent need to raise the awareness among students and educators regarding the paradoxical gap between reality and expectation. This could be achieved through student-centred courses and by introducting reflection, strategic training, reinforcement and transformative educational approaches from educators.

1.3 Midwife's professional identity and its components

There is still diversity of definitions and its component parts when referring to the midwife's professional identity. The concept of professional identity itself does not have a unified definition: "The importance of the concept of professional identity lies in its relationship to professional knowledge and action, but these links are complex. A traditional notion of identity is of something essential about ourselves, a fixed and stable core of 'self'," (Watson, 2006).

In a Constructivist Grounded Theory design study by Zhang (Zhang et al., 2015), the professional identity construction of 15 Chinese midwives with a range of midwifery experience, practicing in three different types of hospital settings in a capital city in Southeast China were explored by individual, in-depth interviews. Some of participants' work journals were also included. In context of actuality, authors noted that: "Midwifery practice in China has been confined to hospital setting and midwifery has become a sub-branch of nursing profession over the last two decades in this context, bringing about a concern of identity crisis for the profession." (Zhang et al. 2015). Authors explored a broad view, in a specific geographical area of China, of midwives' professional identity concept: "Two definitions of the midwife: the external definition ('obstetric nurse'), bound up in the idea of risk management under the medical model of their work organisations; and the internal definition ('professional midwife'), associated with the philosophy of normal birth advocacy in the professional discourse," (Zhang et al. 2015). They also noted the impact of medicalised care on midwifery coping strategies at work, when one of the tools for midwives was detaching the self from the professional identity ('obstetric nurse'), thus making a type of 'hybrid identity', just to cope with the situation at work. The possible solution for identity continuum for internal definition ('professional midwife') was proposed as continuing professional development supported by midwifery discourse.

In the cross-sectional study of Luo (Luo et al., 2024) data were analysed for core competencies of midwifes in China. 150 midwives in 77 town hospitals filled in the valid questionnaire. As results showed: *"*The core competence scores of township hospitals were much lower than those of large-scale hospitals in cities. The demographic characteristics suggested that more than half of the midwives had completed technical secondary education. This indicates that the total educational level of midwives in township hospitals was low, and the number of midwives who graduated from junior college was insufficient*."* (Luo et al., 2024). Midwives have gained a variety of levels of education; some have even gained their professional qualifications at secondary level.

As authors noted:

1) to define clearly a midwife's professional identity and it's competencies remains challenging, as the work jurisdiction among midwives, nurses and obstetricians still remains unclear;
2) research has also shown that highly-educated midwives can provide better care for pregnant women and decrease maternal mortality rates. Improvement in qualifications is vital for core competencies. This indicates that higher education for midwives should be developed to provide educational resources for the advancement of midwives.

Authors concluded that the main factors influencing core competencies were educational background, midwifery working years and professional identity. As the study design was quantitative, midwives' professional identity was reported as 'moderate'. Professional identity is a complex term and research would benefit from broader explanation of this, not just giving it a grade or level.

Vincifori and Min (2014), in a descriptive, quantitative, prospective, observational study, described the professional identity of Italian midwives from the perspective of the application of the Italian Midwives' Ethical Code in their everyday work. The midwife's identity was conceptualised as based on the knowledge and understanding of the body and birth. Authors noted that it was influenced by both the midwife's age and expertise and the healthcare environment. Results showed how midwives see high autonomy alone as insufficient to establish midwifery as a profession. This could be explained by the fact that in Italy only independent midwives can express autonomy as an *alternative* culture to a *hospital* one. The authors concluded: "The most widespread profile emerging from the survey results seems to be the so-called 'hybrid midwife' who experiences the contradiction between what can actually be achieved in a hospital environment and the core values of midwifery" (Vincifori and Min, 2014). Another conclusion from authors was that study could be done with wider sample of respondents. There were aspects that they saw needing to be explored more in qualitative research design, such as continuity of care, autonomy and profession/professionalism. Authors noted that it could be advisable also to extend the survey to a wider and more representative sample from wider range of midwives' professional experience and practice.

Referring to (Divall, 2015, 1, 16) where in her thesis, adopting an exploratory approach, using observational methods regarding identity construction and enactment in midwifery leadership, in transition from clinician to leadership and managerial role, highlights concern of the ageing workforce in midwifery field. Likewise, the damaging impact of poor or ineffective

leadership in the context of a contemporary National Health Service (NHS) policy in context of one region of England is underlined. The aim was to reach a holistic view of that transitioning process. The impact of poor or weak leadership within midwifery has been recognised. The NHS also focused on the importance of clinical leadership defined as leadership for clinicians, by clinicians. The concept of identity construction as an evolutionary process is complex in itself, as it is interdependent between individual, professional group and organisational structure (Divall, 2015, 36, 47). Findings showed that in respective group levels, language and meanings were shared whereas between clinical and leadership groups there appeared a significant variance in meanings of terms such as *midwife*, *management* and *leadership*. Additionally with organisational structures came added complexity. Identity conflict for the participants occurred at the level of the group because difficulties were seen in the challenge of working as hybrid clinical-managerial leaders with a described difference between midwives themselves and non-clinical managers.

The author of this study also noted that:

- organisational structures are partly influencing these results;
- neither individual, professional group, nor organisation works in isolation, and any single element is insufficient to explain questions of identity construction;
- both 'me' and 'we' are of equal importance in transition to and enactment of clinical leadership in midwifery;

"I am still a midwife" clearly holds at an individual level, but is a much more contested theme among clinical midwives in the way they assess the identity of clinical leaders (Divall, 2015, 253).

Divall proposed that future research could be done to explore the highlighted division between groups in relation to the meaning of *midwife* and *manager* or *leader*. In addition future work could focus on addressing the challenge of integrating transformational and transactional leadership models.

Brundell (Brundell et al., 2023) explore in their study the genesis of midwifery education in the Australian setting and explore the impact of the language used to describe the educational backgrounds on the professional identity of midwives. As there nowadays midwives are working alongside with differently gained professional education. Authors highlighted the importance of the language used to describe the midwifery workforce, as any kind of division among professionals, in this case midwives, undermines their sense of professional identity and positivity. It is therefore very important that people choose their words carefully when speaking about midwives. Once registered with the Health Professional Register, all midwives are equal in terms of professionalism: "Midwifery education can occur

through several pathways; however once registered, all midwives are equal" (Brundell et al., 2023). In Australia this is used in the context of direct entrance and midwife and nurse qualification, because midwifery education in the Australian tertiary sector is varied, with multiple pathways to registration as a midwife. Authors noted: "The power of how midwives are spoken to, workforce acceptance, and positive workforce recognition is real and meaningful to the development of professional identity and overall well-being (Brundell et al., 2023). The reflective practice of examining how people use language and adjust to be inclusive is a key element that frames a midwife's professional identity. The language people use to describe the midwifery profession should embody a similar philosophy to the woman-centeredness used when working with women. There was an important note from the authors: "*How do we assist women to identify their strengths when we see deficit in others?"* Conclusions were made, however, that separatist language is still often used to describe midwives according to their educational background, which reduces a positive midwifery identity and influences continuing workforce attrition rates.

Critical discourse analysis was used by Fealy (Fealy et al., 2018) to examine and describe disciplinary discourses conducted through professional policy and regulatory documents in nursing and midwifery in Ireland. Authors highlighted: "A key tenet of discourse theory is that group identities are constructed in public discourses and these discursively constructed identities become social realities. Professional identities can be extracted from both the explicit and latent content of discourse" (Fealy et al., 2018). Authors concluded that the language used in regulatory and policy review documents is important, since it speaks directly to both the practitioner and the public and can make an impact on several unintended functions:

- constructing professional identities for those who are the subject of the document;
- propagating a self-interested version of the profession to wider society;
- to truly engage in interdisciplinary education and research and then have a clearly-differentiated disciplinary identity with a distinct disciplinary discourse.

In conclusions authors of this study also noted that their results support previous studies on discursive constructions of professional identity by demonstrating that professional identities can be extracted from both the explicit and latent textual content of discourse.

Maria Luisa Torres (2003) describes in her thesis abstract her analysed concept of the midwife as the female healer of Latin America. In the process of this study, the collective Andean memory that "the midwife is one of the oldest, wisest, and most respected women of her community" (Torres, 2003) was recovered and analysed. This study described how an Andean midwife works with the woman's body, treating it with respect based on her

accumulated professional work and knowledge. This work also highlighted the attitude towards the female body over time. For example, while exposing the female body was considered shameful in Medieval Europe, this was not at all the case in the Andean region. Evidence of this can be seen in representations of women giving birth in paintings and ceramic work. Such an attitude towards the female body also contributed to the duties of midwives in improving hygiene and public health conditions.

1.4 Summary of Literature review

In the scientific literature, the process of acquiring a professional identity as a midwife is broadly discussed. In particular, the challenges of this process are discussed: the impact of the practicing midwife as a role model; mentoring issues in practical placements; unpleasant issues like disgust in practice and coping with it; the need for specialised study courses to enhance professional values, beliefs and attitudes; the acquisition of professional boundaries for midwives and the ability to perform humanistic caring.

The concept of the midwife's professional identity is still subject to diverse definitions and interpretations. The concept of professional identity itself does not have a unified definition. Different research topics have been explored regarding midwives and how they perceive their professional identity, like

- detaching the self from the professional identity ('obstetric nurse'), thus creating a 'hybrid identity', just to cope with the situation at work;
- the impact of medicalised care;
- independent midwives can express autonomy as *alternative culture* to a *hospital* one;
- division between groups in relation to the meaning of *midwife* and *manager* or *leader*;
- separation between the same professionals – midwives;
- professional identities can be extracted from both the explicit and latent textual content of discourse;
- the midwife is one of the oldest, wisest, and most respected women of her community.

2 Theory of Hermeneutics

"For even within one's own language it is still true that the reader must completely assimilate both the author's vocabulary and, even more, the uniqueness of what he says."
(H.- G. Gadamer, 2013, 197)

2.1 Roots of hermeneutics

Scriptural hermeneutics are regarded as the prehistory of the hermeneutics of modern human sciences. This was based on principle of the reformation, where Luther insisted that we do not need tradition to achieve the proper understanding of Scripture, but that "It has univocal sense that can be derived from the text: *the sensus literalis*" (H.G. Gadamer, 2013, 182). Both traditions, the dogmatic tradition of the church and the reformists, were dealing with a foreign language and not with the scholar's universal language of the Latin of the Middle Ages, so when studying scripture it was necessary to learn Greek and Hebrew and purify Latin. By applying in-depth, acquired language skills for working with texts, hermeneutics tried to reveal the original meaning of the texts in the traditions of both humanistic literature and the Bible. The gaining of understanding of scripture starts with the individual passage and then of the whole with the cumulative understanding of theses individual passages. Even at this time the circular relationship between the whole and the parts was not new (H. G. Gadamer, 2013, 182). Luther and his successors transferred the universal principle of the textual interpretation from classical rhetoric, in which perfect speech is compared to the perfect body, and the relationship between the head and the body, or the whole and its parts, is examined. This meant that scripture should be unified in itself: "In the eighteenth century, men like Semler and Ernesti realised that to understand scripture properly it was necessary to recognise that it has various authors," (H. G. Gadamer, 2013, 183). Gradually the idea of the dogmatic unity of the canon was abandoned. Dilthey called it liberation of interpretation from dogma, and it was recognised that interpretation should be done not only from a grammatical, but also a historical point of view (H. G. Gadamer, 2013, 184).

Schleiermacher and Hegel suggest two very different ways of answering the question of what the task of hermeneutics in relation to understanding might be. Gadamer points out that they might be described as *reconstruction* and *integration*.

Schleiermacher concentrated his understanding on the reconstruction of the work as it was originally constituted. As the art of understanding came under fundamental theoretical examination, neither scripturally- nor rationally-founded theories could explain the dogmatic understanding of text. Schleiermacher extended the hermeneutical task to *meaningful dialogue: "*To understand means to come to understanding with each other with respect to something." The real problem of understanding is not grammatical or linguistic interpretation, but

the question of how it came to such a conclusion. Schleiermacher even defines hermeneutics as *the art of avoiding misunderstandings*. He proposed that historical knowledge introduces the possibility of replacing what has been lost by restoring the original occasion and circumstances in order that the author can really be understood only by going back to the origin of the thought. The criticism was that what is reconstructed or brought back from the past is not necessarily original. Not only is there a need for grammatical interpretation, but also for psychological (technical) interpretation. Psychological interpretation became the main influence in the nineteen century by Savigny, Boeckh, Steinthaland and Dilthey. (H.G. Gadamer, 2013,165,186,187,192,193). Schleiermacher stated that the aim *is to understand a writer better than he understood himself*; an act of understanding is the reconstruction of production.

Hegel states that a definite truth and essential nature of the historical spirit "consists not in the restoration of the past, but in *thought – full meditation with contemporary life*," (H.G. Gadamer, 2013, 168).

Alternative understandings still exist. These include variable and relational experiences that could be subjective and encompass various and multiple possible views which have become accepted over the last hundred years. This leads to a paradigmatic discussion that provokes philosophical and scientific debate about *truth*. Schleiermacher, an early 19th-century scholar, framed this notion as a basis for the art of understanding and contributed to the idea of the dialectical process as a way of understanding that seeks shared and common meaning, including previously-known or hidden understandings, as discussed by Dilthey, Heidegger, and Gadamer (Dibley et al., 2020, Part I, Chapter 1).

Husserl and Dilthey were interested in learning about, or understanding, the structure of human life in the world, or lived experience. Heidegger further expanded this concept of hermeneutics and included three different ideas:

- the definition of hermeneutics as the process by which the *basic structures of Being are made known*;
- hermeneutics is the *working out of the conditions on which the possibility of any ontological investigation begins*;
- *hermeneutics is an interpretation of being there* (Cohen et al., 2000, 5).

Primary traditions of biblical hermeneutics were significantly expanded in the nineteenth century by German thinkers such as those mentioned above (Bernstein, 1983, 142). Dilthey spoke of conscious human experience, studying the action in literary text by the objectification of text in the form of words. By objectifying the experience in text, it could be conveyed to the reader, who could then access this experience through text. Dilthey saw this

as a way for the reader to enter the author's psychology. Interpretation which follows only after comprehension has the author's experience as its object (Alonso Schökel, 1998, 56).

It has also been referred to as 'philosophical hermeneutics' and is described in the works of various existential and critical philosophers, including: Sartre, de Beauvoir, Butler, Derrida, Merleau Ponty, Arendt and others. Contemporary Heideggerian scholars such as Maly, Stenstadt, Dreyfuss, Sheehan, Mitchell and Aho have contributed to our understanding of Heideggerian interpretive phenomenology, while researchers such as Benner, Diekelmann, Smythe, Ironside, Swenson, Sims have developed hermeneutic phenomenology as a methodological approach in their own way (Dibley et al., 2020, Part I, Chapter 1).

Heidegger worked in the sphere of ontology and was therefore concerned with the nature and relations of being. For Heidegger "*what is means to be*" was a way of thinking which included past knowledge, teaching, current everyday experiences and expressions and acknowledged the possibilities of the future: "*He was more concerned with being in the world, rejecting Husserl's being of the world*" (Dibley et al., 2020, Part I, ch.1). Heidegger, uniquely, was considering *being there* and focusing on what it means to be human. This involved reflective questioning of the awareness of a person's situation or place in an ever-changing world and a person's own meaningful existence, that is his – *being in the world*. This term has been translated, sometimes literally, and discussed widely in philosophical literature. Dasein's *being in the world* is a way of having the human experience in their world (Dibley et al., 2020, Part I, ch.1). Heidegger states that humans understand the world in a way that involves their perception of self as the centre of the world in that moment, inseparable and without boundaries, stretching in all directions. He thought that humans interpret the horizons of others through a circular, hermeneutic process, using trial and error, questioning and then correcting and doing this all with shared meanings that are presented to all members of that cultural context (Cohen et al., 2000, 74).

For better understanding Heidegger emphasises the meaning of our prior understandings or prejudices which, in his view, are essential to reflect on before gaining understanding of experience: "*Thoughtful, contextual engagement in a complex world cannot be fully understood without the meditative thinking that leads to open awareness. Meaningful experiences are the constitutive aspects of Dasein, which is characteristic of human nature*". This distinguishes him from others, particularly from his predecessor Hussler (Dibley et al., 2020, Part I, ch.1).

Gadamer extended Heidegger's work through distinct development of his thought.

Hermeneutics of Hans-Georg Gadamer (1900–2002)

The premise of the Gadamer's hermeneutic approach states that the text is part of a larger whole, which the researcher must study and work not only within, but also in repeated dialogue with the respondents and through constant work with researchers' ever-changing preunderstandings (Fleming et al., 2003; Fuster Guillen, 2019; H.G. Gadamer, 2013; Mack et al., 2005; Vermeulen et al., 2022). In this methodological approach the researcher should constantly keep the notes actively evolving and reflect repeatedly to enable himself to interpret heard and/or written words, not just accept how words sound by themselves as understanding is always a movement in kind of circle, which is why the repeated return from the whole to the parts, and *vice versa*, is essential (H. G. Gadamer, 2013,196). Language fills itself with meaning that goes well beyond simply what is said. In other words, the meaning that is embodied by a phrase is far more than the literal meaning of the words themselves (Peck and Mummery, 2018).

Gadamer extended the hermeneutic approach through his diverse development of Heidegger's thoughts and work. Gadamer explained and wrote about his concept of the 'fusion of horizons': a place in space of time, where a person's prejudices come together with Other (with other/-s prejudices and their horizons), resulting in the formation of new prejudices and horizons. It is important to bear in mind that a text is always part of a larger whole. A person's own prejudices and horizons, (as well as those of Other and the newly formed ones) are never constant, but depend on their actual lived and thought experiences in each moment of their life (Dibley et al., 2020, Part I ch.1).

Gadamer's work focuses on the development of understanding, the process of its actual emergence and evolution, in the process of the interpretation period while the interpreter can and is gaining understanding (Peck and Mummery, 2018). Gadamer, in his work on Heidegger's concepts (1989), suggested that hermeneutics is the working out of the conditions under which the possibility of any ontological investigation begins and that this is the appropriate concern of the human sciences. He was not interested in the structure of the phenomena, but in how the phenomena are interpreted. Interpretation on its own should be the object of research. In practice, this means that the hermeneutic phenomenologist should study how people interpret their lives and give meaning to their experiences using language. Gadamer included not only what people write down and say, but also the symbolic activities in which they engage. For Gadamer to have a world means to have a language: "Our experience of the world is bound to language." (Cohen et al., 2000, 254-256, 448). In Gadamer's own words (1989): "*It is literally more correct to say that language speaks us rather than we speak it*," (Gadamer, 1989, 463) In his work "*Truth and Method*" Gadamer explores the Aristotle's relevance to

hermeneutics with *application* or *appropriation* in the act of understanding. The earlier tradition of hermeneutics distinguished three elements:

- subtilitas intelligendi (understanding)[3];
- subtilitas explicandi (interpretation)[4];
- subtilitas applicandi (application)[5].

Gadamer insists that these are not three distinct elements of hermeneutics, but that they are internally related, as every act of understanding involves interpretation, and all interpretation involves application. According to Gadamer, Aristotele's analysis of *phronēsis*[6] enables us to understand the distinctive way in which application is an essential element of the hermeneutical experience: "Gadamer's interpretation of Aristotle is an exemplification of what he means by opening ourselves to the truth that speaks to us through tradition," (Bernstein, 1983, 64). Gadamer states that meaning and understanding are not psychological, but essentially linguistic processes (H. G. Gadamer, 2013, 159,164). It is the work of art or text that possesses meaning, which is not self-contained, it comes to realisation only in and through the *happening* of understanding. This is where concept of *prejudice/preunderstanding* comes along. The concept of prejudice did not originally have the meaning that is currently attached to it as preconceived opinion not based on reason or actual experience [7]: "*In fact, the historicity of our existence entails that prejudices, in the literal sense of the word, constitute the initial directedness of our whole ability to experience. Prejudices are biases of our openness to the world. They are simply conditions whereby we experience something – whereby what we encounter says something to us,"* (Bernstein, 1983, 162,163). This does not mean that we are enclosed within walls of prejudice, instead we welcome new and curious phaenomena. Keep in mind that Gadamer made a distinction between blind prejudice and justified (*berechtigte)*[8] prejudice, that produced by knowledge. According to Gadamer, we should open ourselves to risking and testing our prejudices in order to make this distinction, through dialogical encounter with what is at once alien to us: *"This does not mean that we can ever finally complete such a project, that we can ever achieve complete self-transparency, that we can attain that state which Descartes (and in another way, Hegel) claims is the telos of such a project, the attainment of perfect or absolute knowledge. To think that such a possibility is a real possibility is to fail*

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3 *Subtilitas intelligendi* (Latin lng.) – precision of understanding
4 *Subtilitas explicanda* (Latin lng.) – precision of explanation
5 *Subtilitas applicandi* (Latin lng.) – precision of application
6 *Phronēsis* (Greek lng.) – practical wisdom, or knowledge of the proper ends of life, distinguished by Aristotle from theoretical knowledge and mere means-end reasoning, or craft, and itself a necessary and sufficient condition of virtue (Oxford Reference, 2024)
7 Prejudice – preconceived opinion not based on reason or actual experience, bias, partiality (Oxford Reference, 2024)
8 *Berechtigte* (German lng.) – legitimate

to do justice to the realisation that prejudices "constitute our being": that it literally makes no sense to think that a human being can ever be devoid of prejudices. To risk and test our prejudices is a constant task (not a final achievement)" (Bernstein, 1983, 163). This does not mean that when we listen to someone or read text, we ought to forget our own opinion. To *be open to other's opinions* implies their right to be situated in my own system of opinions, or to be precise, I situate myself in relation to *Other* (Bernstein, 1983, 174).

2.2 Theory of hermeneutic approach in research

Gadamer stated that fundamentally and essentially understanding in Hermeneutic approach is movement in kind of circle (see Figure 3.1), from the whole to the parts and vice versa and as this circle is constantly expanding, as the concept of the whole also could/are changing as being integrated in ever larger contexts always affects the understanding of the individual parts (H. G. Gadamer, 2013,196). Schokel and Bravo offer a clear and understandable definition of a hermeneutic cycle: "*A preliminary description will situate the hermeneutical circle in correlation with the whole and the part, with what is general and what is particular: we understand the part according to the whole and the whole according to the parts; we understand what is general starting from the particular and the particular when referred to what is general*" (Schokel and Bravo, 1998, 74). The authors even make it simpler, describing hermeneutics as the theory of activity of understanding and interpreting the texts. Cohen et al. describe it with the help of the Oxford English Dictionary as the 'branch of knowledge that deals with theories of interpretation, especially of Holy Scripture' (Oxford ED, 2024). Rooting the term in the name of the Greek god Hermes who interpreted and gave messages from gods to mortals (Cohen et al., 2000,10). Holy Scripture as this is the field (Biblical texts) where most hermeneutical activity still often associated with the interpretation. A hermeneutic approach have developed over time (Alonso Schökel, 1998, 22). Hermeneutics is not *exegesis*.[9] According to Schokel and Bravo (1998) *exegesis* is the explanation and interpretation of the text according to its original historical meaning. It is historically-critical work, while *existentialist exegesis* is the explanation of the text according to the meaning it has for interpreter/reader. Both authors explain that hermeneutics is neither exegesis nor a type of it. It refers to an approach to the text to explain its meaning. To succeed in doing it, the interpreter/reader needs to understand what the words mean to the author of the text; how the different statements are grouped, how they are constructed and organised and linked into a unified whole (Alonso Schökel, 1998, 14,15). To do such a deep work with texts, it is

[9] *Exegesis* is a critical explanation or interpretation of a text. The term is traditionally applied to the interpretation of Biblical texts.

necessary to understand the language and events in their cultural, historical and philosophical context: "*for only one who has understood completely both its content and form (language and representation) can explain a work, develop its meaning and describe its internal as well as external connection to other works*" (Ormiston & Schrift, 1990b, 41). This is why in hermeneutics it is so important to aim to understand texts in their coordinates of space and time and in the cultural context where the text was originated. According to Gadamer human beings, long before they understand themselves through the process of reflection, they understand themselves in a self-evident way in family, society, and state in which they live in (H. G. Gadamer, 2013, 289). The difficult and critical work for the interpreter is to recover the meaning the author was trying to convey from amongst several possibilities and where the concept may be expressed with different words (Alonso Schökel, 1998, 31,40). By delving deeply into the text, the interpreter tries to understand the author in all his complexity and richness. The author's work mediates and through it the interpreter tries to understand the author whilst trying not to lose sight of the overall perspective (Alonso Schökel, 1998, 54,55). In order to reach a new insight or understanding, both a re-experiencing of the thinking of the author and an examination of the structure of the sentences and the possible psychological aspects of the author should be undertaken. The process of the *hermeneutical* cycle is dialectical and negotiates between the whole and the parts of the text. Meaning is produced via this process: "*the initial meaning of the lived experience may be 'taken-for-granted' but, by unpacking it or stripping away the initial or superficial meaning, we can uncover more of that which is hidden*" (Dibley et al., 2020, Part I, ch.1). The search for *truth* stretches back as far as humanity has asked itself "what is *truth*?". Its claims differ across paradigmatic perspectives. In the last two hundred or more years there has been a dominance of thought deriving from a scientific tradition where neutral and objective understanding based on rational, experimentally tested processes is considered indisputable (Dibley et al., 2020, Part I, ch.1).

Hermeneutic research can be done by an individual or team of researchers. Cohen states that often what researchers learn about themselves whilst doing research is the most important part of the process (Cohen et al., 2000, Part X, ch. 2). Shockel and Bravo (1998) explain hermeneutical method as the theory of comprehension and interpretation of literary texts. During the process of undertaking hermeneutic research, researchers' analysis goes outside the context of the individual interview as well as the context of the individual participant. In the hermeneutic research process, working with the text, information is exchanged between author/respondent and interviewer in both directions. Gadamer even emphasises that: "We say that we conduct a conversation, but the more genuine a conversation is, the less its conduct lies within the will of either partner." (H. G. Gadamer, 2013, 401). The interview itself is relatively

unstructured and the emphasis of it is on listening to whatever the respondent says as opposed to guiding and controlling the dialogue (Cohen et al., 2000, 61, 73).

Using a hermeneutic cycle approach in the interpretation of findings, the smallest statements must be understood in terms of larger cultural and time-related context (H. G. Gadamer, 2013, p. 289). All aspects of context must be taken into consideration: the person, the family, the community, and so on. Every interview and every field note are read and thought about individually. By repeatedly reading the full set of findings and then going back to the individual interviews, the researcher can make sense of the whole picture. This process is repeated so that the researcher can comprehend the broader culture of the respondent from both separate and grouped sources (Cohen et al., 2000, 74).

Although hermeneutical researchers are scientists and usually use a form of writing analysis which is predetermined and rather rational, there are some important variations inside this predefined format. The respondents, the form of the findings and the larger goal of the research drive these variations. For example, discovering in the field that the wrong question was asked and adjusting it by asking another can salvage the study and further work in discussion and a new set of aims created (Cohen et al., 2000, 93, 95). Analysis of finding begins with the collection of these findings. The earliest understandings of the findings that emerge from initial analysis should be subjected to scrutiny before more findings are collected. This work should always be done in written form. When the researcher is writing about his or her relationships with findings and preunderstandings, it should be noted when and how different understandings emerged, and in how many forms. In what ways did the researcher challenge his or her own preunderstandings of findings, and to what extent were preunderstandings and preliminary interpretations tested over the course of the research. According to the methodological approach of Gadamer's hermeneutics, the researcher should recognise from the outset that all understanding inevitably involves some preunderstandings, which give the hermeneutical problem its real thrust (H. G. Gadamer, 2013, 283). Researchers should be aware of their participation in the narratives collected and the scientific accounts written and yet to be written. This work serves not only as a record of the analytical process, but also because the act of writing itself forms the research process. This critical reflection makes the research process rigorous. It is important for researchers to do whatever necessary to maintain critical reflection throughout the period of study and to maintain full engagement in the shared life experience of respondents (H. G. Gadamer, 2013, 281, 283). This is described by an outdated and problematic qualitative research metaphor as "*using the self as an instrument*". This internal reflection is done primarily through writing and can be recognised

in the writing after completing the work, where the researcher carefully records these decisions, along with a written justification for making them (Cohen et al., 2000, 74, 89, 90).

Analysis of findings in a hermeneutical approach involves moving from the field text to a narrative text that is meant to stand alone for other readers. This process of moving between texts continues throughout the study, with the field text being read and reread in multiple ways and in no predetermined order. While doing this reading and rereading, writing and rewriting, the narrative text occurs. Analysis begins during the actual interviews by way of active listening and thinking about the meaning of what is being said (H. G. Gadamer, 2013, 282). Possible understandings for theses meanings may begin to be constructed. Repeated interviews with most of the respondents are an essential feature of the hermeneutic method when used with an advanced approach (H. G. Gadamer, 2013, 403). Often respondents are asked to validate these understandings after careful analysis of transcripts has been done, reading the findings many times and working with field notes and the researcher's own preunderstandings and newly-emerged or changed understanding. This phase of the work is sometimes called "*immersing oneself in data*". This is followed by the phase of analysis that could be called transformation or reduction of findings into what is relevant and what is not (H. G. Gadamer, 2013, 284). This process is similar to editing. Findings can be examined line by line and all important parts are labelled with preliminary theme names. The next task is to extract the passages with similar themes to look at them together and alongside passages that have the same label, but are separated from the rest of the text. During this process, notes are also made regarding how many respondents contributed to each of the labelled categories, which respondents contributed to a certain cluster of categories, how many interviews a relevant category appeared in, and whether it appeared for the first time in the first, second or third interview.

Fieldnotes and relevant narratives are used to create context and to clarify the themes from the findings during the process of writing and rewriting. As mentioned previously, themes can be verified with the respondents to ensure that the themes appropriately capture the meaning that respondents meant to convey. Respondents often reflect on their experience after being interviewed, which can lead to enriched findings (Cohen et al., 2000, 62, 64, 76, 81, 82, 97).

Over the last three decades, the way we use language has constantly changed as new technologies, the internet, mobile phones, and software systems such as spellcheck have shaped the way we use words and structure sentences. We should be aware that even when composing a short letter or message, new technologies even provide the possibility to finish our sentences. One could argue that these might be the same words the person would have chosen to use by themselves, as the system only gives those choices the algorithm had previously identified, just

more quickly than the human writing, but we still may never know what words would have been used had the system not suggested any. That leaves oral language as unique and without AI (artificial intelligence) suggestions, at least for the moment. Walter Ong described this returning to work with oral language as "*oral hermeneutic*" (Ong, 2018, 3). He pointed out how easy it is to stand out in the era of modern technology by using all kind of media platforms, and yet at the same time lose one's own voice in the sea of others: "*Single person's 'voice' can go viral and have an enormous impact, the anonymity and scale of big data can absorb and override the voice of the single interpreter. Because we are awash in information, we need a corresponding hermeneutic language to unify it for ourselves, to turn data into knowledge, and to maintain the centrality of the individual voice."* (Ong, 2018, 6).

2.3 Summary of Theory of Hermeneutics

Scriptural hermeneutics is regarded as the prehistory of the hermeneutics of modern human sciences. Gradually the idea of dogmatic unity of the canon was abandoned. Primary traditions of biblical hermeneutics were significantly extended in the nineteenth century.

Although hermeneutical researchers are scientists and usually use a form for the written analysis which is predetermined and rather rational, there are some important variations within this predefined format.

The premise of Gadamer's hermeneutic approach states that the text is part of a larger whole, which the researcher must study and work not only within, but also with repeated dialogue with the respondents and constant work with the researcher's ever-changing preunderstandings. In this methodological approach the researcher should keep his notes as a constantly evolving process and reflect repeatedly to enable himself to interpret heard and/or written word rather than what it sounds like by itself. Language fills itself with meaning that goes well beyond simply what is said. In other words, the meaning that is embodied by a phrase contains far more than the literal meaning of the words themselves. Gadamer, in his work on Heidegger's concepts (1989), suggested a second definition of hermeneutics as the working out of the conditions on which the possibility of any ontological investigation begins and is the appropriate concern of human sciences. Gadamer was not interested in the structure of phenomena, but in how phenomena are interpreted. Interpretation on its own should be the object of research. In practice this means that the hermeneutic phenomenologist will study how people interpret their lives and make meaning of their experience using language. Gadamer included not only what people write down and say, but also the symbolic activities in which they engage. For Gadamer to have a world means to have a language. Gadamer states that meaning and understanding are not psychological, but an essentially linguistic process. It is

the work of art or text that possesses meaning which is not self-contained and comes to realisation only in and through the *happening* of understanding. This is where the concept of *prejudice* emerges.

3 Method

Humanistic studies, as their long traditions reveal, require ambience where talk and dialogue are cultivated, where ones feel free to pursue issues and problems that transgress conventional academic boundaries, and where one directly experiences the challenges and encounters that come from colleagues and students with diverse intellectual concerns.
(Bernstein, 1983,16)

3.1 Introduction, reasoning for choosing Gadamer's hermeneutics

The choice of Gadamer's hermeneutics for the research into a midwife's professional identity in Latvia was based on reasoning that it is an especially complex question due to the historical, social, economic and cultural changes that have taken place in recent decades. The premise of Gadamer's hermeneutic approach states that the text is part of a larger whole (H. G. Gadamer, 2013, 282), which the researcher must study and work not only within, but also in repeated dialogue with the respondents: "Language fills itself with meaning that goes well beyond simply what is said. In other words, the meaning that is embodied by a phrase is far more than the literal meaning of the words themselves" (Peck and Mummery, 2018). The goal of hermeneutic research is achieved only when, by writing down and listening to stories that resonate with others, and by repeatedly conducting a dialogue with the respondents (the 'hermeneutic circle'), a mutual understanding is discovered between the researcher, the common text and the respondents. According to Gadamer the 'hermeneutic circle' is constantly expanding, since the concept of the whole is relative, and being integrated in ever larger contexts always affects the understanding of the individual part (H. G. Gadamer, 2013, 196). This mutual understanding provides an opportunity to understand the phenomenon of a midwives' professional identity, adapting to this research project the developed research method of Gadamer's hermeneutics by Fleming et al. 2003, which consists of five main steps in research progress (see "Conceptual model", Figure 3.1):

1 Deciding on a research question.
2 Identification of the author's preunderstandings or prejudices.
3 Gaining understanding with participants and repeated identification of the author's preunderstandings or prejudices.
4 Gaining understanding through dialogue with text.
5 Establishing trustworthiness (Fleming et al., 2003).

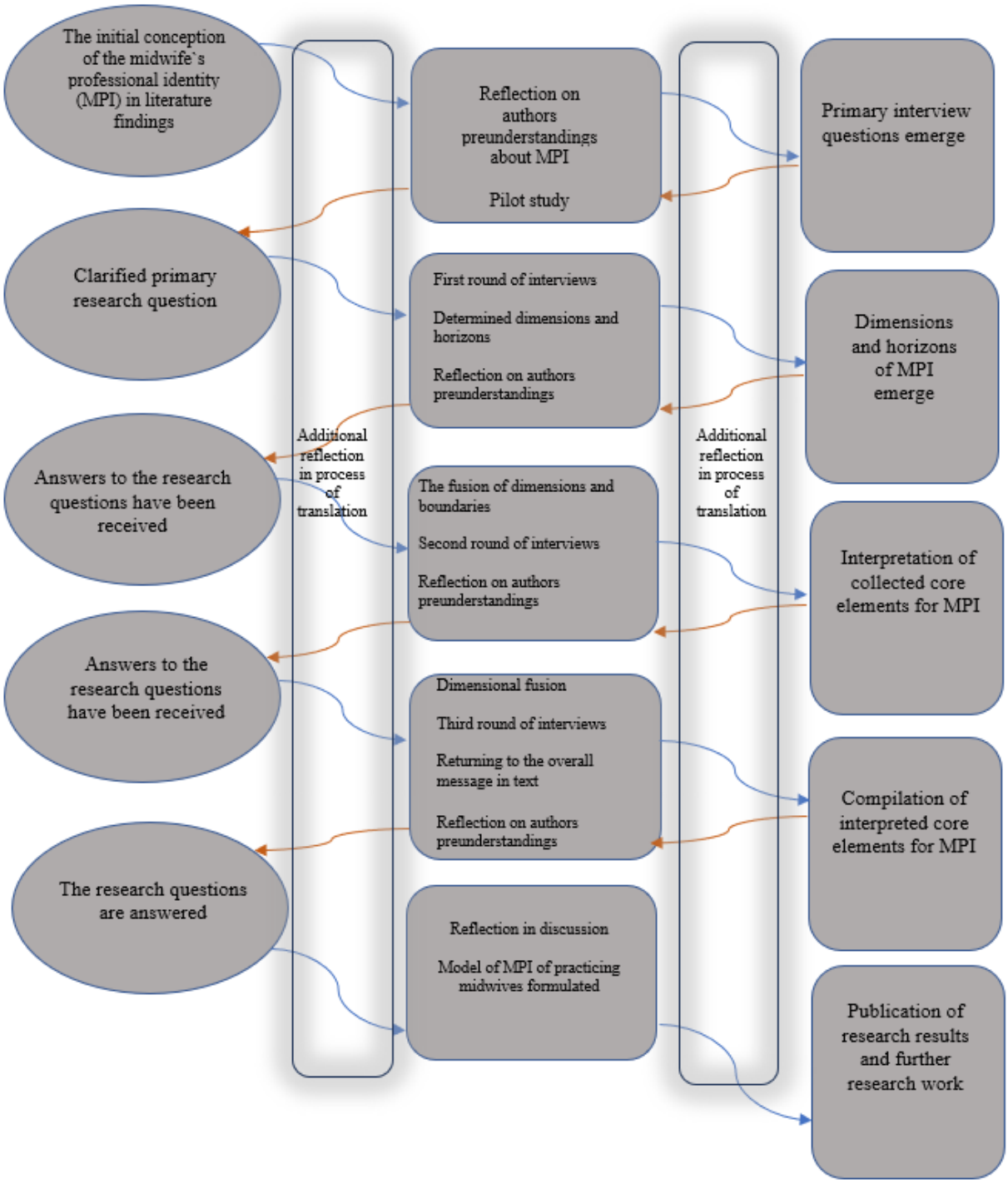


Figure 3.1 **Conceptual model for research "Midwife's Professional Identity in Gadamer's Hermeneutic Perspective"**

(Modelled after (Fleming et al., 2017; Paterson & Higgs, 2005)

3.2 Deciding on primary questions – step one

My work started with my own reflections on prejudices concerning a midwife's professional identity together with its concept in literature and contemplation on it (Dykes, 2005; Fitzgerald, 2020; Gardner & Shulman, 2005; Kalet et al., 2021; Rennie, 2012). Through working with these literature findings, I concluded that the concept of a midwife's professional identity is not what must be understood. Rather, it is how the midwives themselves perceive

this identity that must be fully understood: how do they perceive their own professional beliefs, values and norms? This is the great unknown that nobody, even practicing midwives in this country today, has considered. Through contemplation and reading of different concepts and their constituent components, the clearest and most helpful set of guidelines when creating the research question of this topic was found in the definition of professional identity elements by Dollarhide et al. (2023) in their research on the development of professional identity in literature:

- personal and professional behaviours;
- ethics;
- values;
- world view (Dollarhide et al., 2023).

In describing my own beliefs, perceptions and prejudices, before starting collecting the interviews for this research, I received help from a consultant midwife who was responsive and agreed to help to conduct several interviews with me about my perception of this theme. She was instructed to '*keep me on track*' during reflective discussions, to create a clear summary of my own initial preunderstandings and, after each interview round, a further summary of evolving themes surrounding the components of the concept of a midwife's professional.

After creating some of my own questions, I conducted a self-reflective discussion with a consultant midwife to discuss both what had been found in the literature and my own proposed research question. Such self-reflecting discussions were also conducted after each round of interviews. According to Gadamer's hermeneutics, it is necessary to keep one's gaze fixed on the subject throughout all the constant distractions that originate in the interpreter himself, because a person who is trying to understand a text is always projecting and sees emerging initial meanings in the text because he is reading the text with particular expectations in regard to a certain meaning. Working out this fore-prejudice, which is constantly revised and self-reflected in terms of what emerges he penetrates in to the meaning, is understanding what is there (H. G. Gadamer, 2013, p. 279). The consultant midwife was instructed to lead the discussion with questions relevant to the research topic. This consultant midwife was chosen for this research not only because she is so responsive, but because of her broad work experience and professional abilities, her work experience in a big maternity home, a small rural hospital, in educational work with youth and parents-to-be and in homebirth. The chosen consultant midwife for this step in the research has no benefits or financial interest in the study or its findings and results (Cohen et al., 2000, p. 91).

It was also discussed with my supervisor for this Thesis.

3.3 Work with preunderstandings and continuous reflective work – steps two and four

Before starting the research work, the researcher himself must define any preconceptions or preunderstandings of the researched object/concept. Such a research method assumes that it is impossible to start research in the hermeneutic process as a '*tabula rasa*'[10] without prior experience of the subject (Fleming et al., 2003; Maxwell, Ramsayer, et al., 2020). The work began with the literature review and the author's repeated discussion with the consultant midwife. The goal was to proceed with reflecting on my (as the author's) preunderstandings and prejudices about a midwife's professional identity. It impossible to eliminate one's preunderstandings as everyone always has a preunderstanding of the topic in question (Fleming et al., 2003). These 'prejudices' or 'preunderstandings' (Maxwell, Ramsayer, et al., 2020) enable us to perceive and experience things differently (Corcoran & Cook, 2023; H.G. Gadamer, 2013; Peck and Mummery, 2018). Given the abundance of guidelines and protocols on how midwives should work, behave and conduct themselves at work, and the absence of published research projects in Latvia, how do the midwives themselves see their professional identity?

Interviews with consultant midwives were made several times, before starting and after each round of interviews. They were voice recorded and transcribed, making it possible to listen to them repeatedly while reading the transcripts during the continuing work reflecting on my own changing prejudices. As according to Gadamer's Hermeneutics, researcher should remain open to the meaning of the other person or text, but this openness always includes our situating the other meaning in relation to the whole of our own meanings or ourselves in relation to it. Researcher in this kind of methodological approach is prepared for text to tell him something, but at the same time he is aware of one's own bias. Accepting that the text can present itself in all its otherness and thus assert its own truth against one's own prejudices (H. G. Gadamer, 2013, 281). Researchers underpinning their work with the philosophy of Gadamer are required to identify their preunderstandings or prejudices regarding the given topic. Reflecting upon these enables them to move beyond their preunderstandings to understand the phenomenon and to transcend their horizons. This in turn influences the research findings. In order to facilitate the process of understanding, the first series of interviews should be analysed before proceeding with the next sequence (Fleming et al., 2003). In all five steps of the research process, handwritten notes were constantly made and work with the text continued throughout. This is because, as was explained by Gadamer, the use of the spoken-word conversation is not always

[10] Tabula rasa – blank slate, a situation in which there are no fixed ideas about how something should develop, Dictionary, O. L. s. (2025). Oxford Learner`s Dictionary. In.

meant to be literal; rather a person in a quest to obtain a new understanding of a text might be in conversation with that text, as if to keep track of the author's thoughts on research topic and unfolding and changing preunderstandings (Corcoran and Cook, 2023). Discussions were audio recorded and transcribed within 48 hours with my notes added. This was made with repeated reading and making of notes. The repeated reviewing of the author's preunderstandings should be performed according to Gadamer's hermeneutic method to ensure not only that research '*goes in the right way*', but also to make conscious what was unconscious. Preunderstandings or prejudices characterise a person's range of vision at a specific point in their life, which can be perceived and challenged throughout their life experiences and situations. They are also however flexible and dynamic in their nature, meaning that they can change during or after experiences that are made during reflective processes (Maxwell, Ramsayer, et al., 2020).

During the entire research process, in addition to interview texts, field notes and transcripts with their analysis and rewritings, hand-written journals were also kept close at hand as and additional work tool to aid the continuing process of reflection. The same issues arose for both hand-written and digital notes: "*the journal entries also document changes in the researcher's perspective that occur over the study through dialogue with participants. Once written, the journal entries, as part of the field text , can be read an d reread in multiple ways as part of the analytic process.*" (Cohen et al., 2000, 88). By accurately dating the notes, it was also possible to trace the period in which the preliminary and newly-emerged understandings of the research topic were formulated from the perspective of the hermeneutically-cyclical research process (see Table 3.1).

After each round of interviews and following initial thematic analysis of the texts, with repeated listening and moving from the whole to individual parts in the texts and back, reflective work on my own interviews with the consultant midwife also were performed and transcribed. Reflective notes were constantly made to maintain an accurate time-line of my ever-changing prejudices concerning a midwife's professional identity and the core elements and factors influencing it.

3.4 Interviews: gaining understanding with participants and repeated identification of the author's preunderstandings or prejudices – step three

A total of 90 interviews were conducted in the form of 3 rounds for each of 30 participants.

After work with my own prejudices and literature findings, a pilot study with thematic analysis and involving 20 midwives was conducted. This was to ensure that initial questions were appropriately chosen and formulated (Ho et al., 2017).

Primary questions:

- What/who is a midwife?
- How do you feel about being a midwife?
- What is it like to be a midwife?
- What do you like about being a midwife?
- What is the hardest thing about being a midwife?
- Have we changed during your time in the profession? If so, how?
- How do the women, children and families, encountered during perinatal care, change?
- What could be said about the work of a midwife to those who think they could do this work? (*How could the professional identity of a midwife be described?)
- What is the most beautiful thing you have experienced in this job?
- What have you learnt from being a midwife?
- What are the incidents from your work that you remember over and over again?
- How do you like to relax and gather your strength?
- What would you like to say to all other midwives?
- What would you like to say to women who are expecting?
- What else would you like to say about midwifes profession?

Before starting each interview recording, in each of the of three rounds, the following information was repeatedly explained to participating midwives to ensure that they understood and agreed to the:

- possibility of ending participation in this research at any moment;
- possibility of pausing participation, whenever necessary for the participant;
- possibility of not answering any of the questions;
- opportunity to ask any questions at any time of the interview;
- lack of any kind of reward for participation in this study.

If the midwife agreed, the audio recording was started and midwife stated her consent with words: “Yes, I agree to participate.”

In the first round of interviews, the originally-developed questions were asked (see Figure 3.1). The questions of the next two rounds of interviews were largely determined by the initial responses and by my reflection on them, together with the distribution of themes that initially emerged in each interview separately and in the common text of all interviews. Before each of the interviews, the text of the previous and all common interviews was reread and listened by me repeatedly, so that during the interview it was possible to question each

midwife in depth about her perceived professional identity and its core components and all other various factors and circumstances that influence and determine this identity (Suddick et al., 2020). The time gap of 7–15 weeks between interviews allowed me to reflect on what was heard, as well as sometimes on what was expressed through pauses, sighs, gestures or mimicry. This also helped to define what I should ask about in more depth or again in the next interview.

3.5 Trustworthiness and continuous reflective work – step five

As Gadamer's hermeneutics require, the trustworthiness and its components, credibility and confirmability should be established by using several rather than just one round of interviews. The researcher can establish credibility by ensuring that the perspectives of participants are represented as clearly as possible. The use of direct quotations from the texts can help the reader to make judgements in this area. Confirmability can be dealt with by returning to participants at all stages of the research process (Fleming, Gaidys and Robb 2003).

This was the reason for me to read and reread each interview several times as well as listen to them repeatedly, not only when the themes were highlighted and put together. The entirety of the text was read again and again, as well as all the collected interviews to reach an understanding of the text as a whole as opposed to its highlights and common themes. My reading of them together and separately was conducted between interview rounds while reflecting in hand-written notes about both them and my own emerging and changing prejudices (see Annex 1). Handwritten notes were a helpful way of clarifying my perceptions of interview findings and my changing prejudices and of defining the next interview questions (Kiefer & Velay, 2016; Vinci-Booher & James, 2020).

To ensure the best possible understanding of midwives' perceived professional identity, at the end after my reflection on the third round of interviews, midwives were given their own transcript of all the interviews one by one to read through and to contemplate with the possibility of editing their text. No thematic changes were made and no one asked for any parts of the text to be excluded. There were 4 midwives who asked for some linguistic style corrections of specific terms or chosen phrases within their transcripts. This was acknowledged and corrections performed in the transcripts.

3.6 Ethics

In the research process, the basic principles of research ethics set out in The Declaration of Helsinki (Ashcroft, 2008, 141) were ensured: the participation of research participants was based on the principle of free will and autonomy and the principle of beneficence, where through taking part in the process and as a result of the research, participants are not exposed to any additional social or psychological risk. As far as possible the principles of justice and

the fourth principle proposed by several scientists, namely respect for the specific community, were also observed (Mack et al., 2005; WMA, 2024). After formulating the interview questions and before starting the interviews, the author made an additional reflection on the ethical principles adapted from the formulation of Miles and Huberman (Miles and Huberman, 1994):

Value of the project: Will the research make any significant contribution to midwifery?
Limits of competence: Do I have the knowledge to do the research and am I ready to learn and consult with other midwives?
Informed consent: Are midwives fully informed about the study?
Benefits, costs and reciprocity: What do midwives gain?
Harm and risk: Is there any way in which this research could harm midwives?
Honesty and trust: Am I telling the truth, and do we trust each other?
Privacy, confidentiality and anonymity: How identifiable are individuals?
Integrity and quality: Was research conducted carefully, thoughtfully and correctly by any reasonable set of standards?

This study received approval from the Ethics Committee of Rīga Stradiņš University (approval No 2-PEK-4/562/2023, 31.08.2023). Participants were informed before starting each interview that they would not receive any compensation.

3.7 Timeframe and sample size

Three rounds of 30 interviews (90 in total) were performed, with a time gap between them of between several weeks and a couple of months (7 -15 weeks). Interviews were conducted with each of the thirty participating midwives, one to one, without the presence of third parties and in a place and manner that was most convenient for the midwife being interviewed. 28 midwives of 30 chose to conduct interviews remotely in the format of a video call; 2 chose to have a walk in the forest for each interview round. Both the time and place of each interview were set according to the participating midwife's wishes in order to be most convenient and least disruptive to their personal or professional life. After conducting each audio-recorded interview, they were transcribed within between 24 and 48 hours and notes were taken, according to the notes made during the interview by the author, according to the methodological instructions (see Table 3.1).

Table 3.1

Timeframe

08.2023.	09., 10.2024.	10.2023–06.2024.	07.2024.	08.2024.
Starting the work with my own preunderstandings and Ethics Committee approval	Pilot study with thematical analysis of midwives' (n 20) perceived professional identity	Three interview rounds with all the study participants – practicing midwives (n 30), all together 90 interviews	Compilation of interpreted MPI, core values and beliefs	Publication of research results and further research work
Work with my own preunderstandings and continuous reflective work: 1 Before starting the interviews; 2 After each of 3 interview rounds; 3 During the entire research process, in addition to interview texts, field notes and transcripts with their analysis and rewritings, hand-written journals were also kept close at hand as an additional work tool to aid the continuing process of reflection. The same issues arose for both hand-written and digital notes.				

As this is a study of qualitative design study, the focus was not on the biggest possible sample size, but on the meaning of the research object, namely, the perceived professional identity of the practicing midwife. Also, according to the literature on research methodology, the seemingly simple question of sample size in qualitative research can provoke debate and lengthy discussion (Leavy, 2014). This meant that the main questions in this study were *how* and *why*. The sample size of participants was planned so that it was possible to obtain practicing midwives' perceptions in different territories and various professional fields, in order to gain broader insights into the saturation of the research results (Dworkin, 2012). The amount of time available to me during the period of unpaid leave from the workplace was also taken into account, and therefore also the real opportunities to conduct undisturbed process of work for interviews, their transcripts and further work with the texts and my own reflections (see Table 3.1). Sample size on a qualitative study by Malterud et al. should be decided in account of:

1) the aim of the study,
2) sample specificity,
3) use of established theory,
4) quality of dialogue, and
5) analysis strategy (Malterud et al., 2016).

According to the guiding principles of Malterud (Malterud et al., 2016):

Aim: The sample size was determined by the aim of the study, namely, to gain understanding of a midwife's perceived professional identity. It was chosen to be considerable for a qualitative design, as the aim of the research was quite broad.

Specificity: The sample size was also determined by the need for participants to have characteristics highly specific to the study aim. This is why participants were currently practicing midwives from different professional and geographical areas.

Use of established theory: The theoretical framework offers models and concepts that may help to explain the relations between different aspects of findings obtained. This is why Gadamer's hermeneutics were chosen: it views the text as a larger whole, which the researcher must study and work not only within, but also in repeated dialogue with the respondents.

Quality of dialogue: The value and quality of the findings is difficult to predict in advance. It depends on the skills of the interviewer, the speech clarity and style of the participant and the chemistry and level of openness between the interviewer and study participant. This was another reason to choose a sample of considerable size.

Analysis strategy: Thirty midwives were chosen for interview to provide deep and broad-spectrum insights into the perception of professional identity. The fact that the work would be continuous with participants' and my own preunderstandings constantly under review over the course of three rounds of thirty interviews, was kept in mind.

3.8 Engaging the participants, their characteristics

In this research study midwives were gathered by the 'snowball' method. Altogether 30 participants were asked for their voluntary participation in this study. If they agreed, a letter of informed consent was given to each of them, using contact details they had provided. To obtain as many different perspectives as possible regarding a midwife's perception of professional identity in different parts of Latvia, the sample of interview participants was formed according to the 'snowball' method, the territorial principle and from various professional profiles (see Table 3.2)

None of those approached refused participation in the study. The group of midwives was created to represent a variety of different midwifery working area sectors and geographical locations.

Selection criteria for participating in this study:

- currently practicing midwife;
- work experience of at least two years;
- agrees to the interview.

Table 3.2

Characteristics of interviews participants

Midwife	Work experience in midwifery less than 5 years	Work experience in midwifery 5–10 years	Work experience in midwifery 10–20 years	Work experience in midwifery 20 years and more	Work in antenatal care	Work in intranatal care	Work in postnatal care	Work in reproductive health care consultations and other	Work in public health care system	Work in private health care system and homebirth
1.			■			■	■	■	■	■
2.		■			■	■	■	■	■	
3.				■	■	■	■	■	■	■
4.				■	■	■	■	■		■
5.		■					■		■	
6.				■		■			■	
7.			■			■	■		■	
8.				■	■	■	■		■	■
9.			■			■			■	
10.				■	■	■			■	
11.			■			■	■		■	
12.				■		■	■	■	■	
13.			■			■			■	
14.				■		■	■		■	
15.				■		■	■		■	
16.		■			■	■	■	■		■
17.				■		■			■	
18.		■				■	■		■	
19.		■				■	■	■	■	
20.	■					■	■		■	
21.				■	■	■	■	■	■	■
22.				■	■		■			■
23.				■			■		■	
24.	■					■	■		■	
25.	■					■	■		■	
26.		■				■	■	■	■	■
27.			■			■	■		■	
28.		■			■	■	■		■	
29.				■	■	■	■		■	
30.				■		■		■	■	

* In compliance with the principle of confidentiality and non-harm and taking into account the small number of practicing midwives in Latvia, the Table does not indicate territorial distribution

Since the work of midwives is related to being around and supporting the birth of a new life, it seemed only appropriate for the respondents to create a code name from the plant kingdom in the original Latin form. The list of these codes was compiled before the midwives were approached and was kept separate from the rest of the work in paper form, and its location is known solely to me as the author. Code names were assigned according to the list, as to the order of involvement of midwives in the study. The Latin titles were created not only for their original sound, but also to create the opportunity for me to work in a more focused way on the text of the transcripts itself and the message it carried. This was also necessary because during the third round of interviews, each midwife by herself and without the use of the coded

name, was given the transcripts for review. The overall message of the text was conceptualised in each conversation with the midwife as we mutually agreed on its credibility.

3.9 Language

All interviews were conducted in Latvian, but I wrote the Thesis in English. This could create even more of a challenge than doing the interviews and thesis in the same language. As language also influences what can be expressed in the means of the words, there are linguists who even state that social reality as experienced is unique to one's own language (Nes van et al., 2010). However, I recognise it as beneficial circumstance for work done in Gadamer's hermeneutic perspective, because it demands extra contemplation and extra reflection on what was said, heard, observed, written and interpreted. According to Gadamer, in the perspective of hermeneutical approach, the main question is not the correct mastery of language but coming to a proper understanding about the subject matter, which takes place in the medium of language. As language can be learned so perfectly that using of it no longer means translating to one's mother tongue, but even thinking in the foreign language (H. G. Gadamer, 2013, 403). This additional translation served as a helpful instrument for me, giving me an additional reason to return to each step to check the interpretation, as the interpretation of meaning is seen as the core of qualitative research (Nes van et al., 2010). To ensure the same meaning was conveyed in the most precise way:

- all transcripts were made in the same language as the interviews: Latvian. Only the highlighted themes and quotes were translated into English;
- translated highlights and quotes were discussed with the consultant midwife who is a bilingual Latvian and English speaker;
- a professional linguist and native English speaker was also engaged;
- to enhance my own English during the period of writing this Thesis I read all literature, not only that required for this research, in English. This was based on the view that considers language to be an aid to thinking, even if it is still not known how exactly it has been stored or processed (Jackendoff, 2009).

The decision to conduct interviews in Latvian was reached before even starting the pilot study to ensure the most convenient and broad way for midwives to talk about their perceptions in their mother tongue. It was clear from the beginning that to translating only the highlights and quotes was the best idea. This was decided to ensure the best possible way to gain the answers to the research questions and understanding of the midwives' perceived professional identity. According to recommendations this was clarified from the first steps of the research (Abfalter et al., 2021).

As bilingual conducted studies and written articles become more common, there is also available criteria for evaluation of translation in qualitative research. Referring to the Mandal methodological guidelines in bilingual research (Mandal, 2018):

- Researchers need to evaluate their own qualifications and experiences in translation. This was done by evaluating my own experience in work with texts, creating materials for students, teaching work and research activities already done in English;
- Researchers may assume different roles during the translation process as interviewers or translators, and this was precisely how it was done in the creation of this Thesis;
- Resource limitations need to be considered. Serious considerations were made regarding when and in what way to involve a professional linguist.

Overall working within two languages in this research was additionally helpful research tool as it provided constant rethinking of used words and sentences, constantly seeking for the best possible creation of the precise thoughts' transformation to the written words. According to Gadamer's Hermeneutic approach, possibilities of our knowledge seem to be far more individual than the possibilities of expression offered by language. As faced with the socially motivated tendency towards uniformity, whereby language forces understanding into particular schematic forms which hem us in, our desire for knowledge tries to escape these schematisations and predecisions (H. G. Gadamer, 2013, 419).

3.10 Summary of the Method

Gadamer's hermeneutics were chosen for the research into the complex subject of a midwife's professional identity in Latvia. It is especially complex due to the historical, social, economic and cultural changes that have taken place in recent decades. The premise of the Gadamer's hermeneutic approach states that the text is part of a larger whole, which the researcher must study and work not only within, but also in repeated dialogue with the respondents.

The goal of hermeneutic research is achieved only when, by writing down and listening to stories that resonate with others and repeatedly conducting dialogue with the respondents (the 'hermeneutic circle'), a mutual understanding between the researcher, the common text and the respondents is reached. This mutual understanding provides an opportunity to understand the phenomenon of a midwife's professional identity by adapting the developed research method of Gadamer's hermeneutics by Fleming et al. (2003) to this research project. This research method consists of five main steps in the research process (see Figure 2.1):

1 Deciding upon a research question

2 Identification of the author's preunderstandings or prejudices

3 Gaining understanding with participants and repeated identification of author's preunderstandings or prejudices
4 Gaining understanding through dialogue with text
5 Establishing trustworthiness (Fleming et al., 2003)

The work began with my own reflections and contemplations on prejudices regarding the professional identity of midwives and the concept of this identity in literature. Before starting the research work, the researcher himself must define what 'prior understanding / preunderstandings' of the researched object/concept he might have. Such a research method assumes that it is impossible to start research in the hermeneutic process without prior experience of it (Fleming et al., 2003; Maxwell, Ramsayer, et al., 2020).

During the entire research process, in addition to interview texts, field notes and transcripts with their analysis and rewritings, handwritten journals were also kept nearby. These hand-written notes and the continuous process of reflection used as research tools were subject to the same issues as digital ones: "The journal entries also document changes in the researcher's perspective that occur over the study through dialogue with participants. Once written, the journal entries, as part of the field text, can be read and re-read in multiple ways as part of the analytical process." (Cohen et al., 2000, 88). In total ninety interviews, comprising three rounds for each of the thirty participants, were made.

After work with my own prejudices and literature findings, a pilot study with thematic analysis with 20 midwives was conducted to ensure the initial questions were appropriately chosen and formulated (Ho et al., 2017).

The time gap between interviews allowed me to reflect on what was heard, as well as sometimes what was expressed through pauses, sighs, gestures or mimicry. It also helped to define what I should ask about once again or in more depth in the next interview.

To ensure the best possible understanding of midwives' perceived own professional identity, after my reflection on the third round of interviews, midwives were given their own transcript of all their interviews to read through and contemplate with the possibility editing the text.

This study received approval from the Ethics Committee of Rīga Stradiņš University (approval No 2-PEK-4/562/2023, 31.08.2023).

4 Findings

"No one knows in advance what will "come out" of a conversation."
(H. G. Gadamer, 2013, 401)

Overall, in this research, four main themes of midwifes' perceived professional identity, along with their subthemes and intertwining elements, were conceptualised:

1 The core elements of a midwife's professional identity:
   - Love for humanity and belief in God / higher power and a woman's own ability and a midwife's ability 'to go with the flow';
   - Variation in the ability 'to go with the flow';
   - Courage and persistence;
   - Professional education and experience;
   - Practice of reflection and self-examination;
   - Changes in perspective after their own childbirth;
   - Ability to draw boundaries and attain professional/private life balance;
   - Look back at the Covid period and reflect on that period's values;
   - As core hindrance, but regrettably constant element of midwife's professional identity nowadays, midwives noted overwork and struggles with finances.

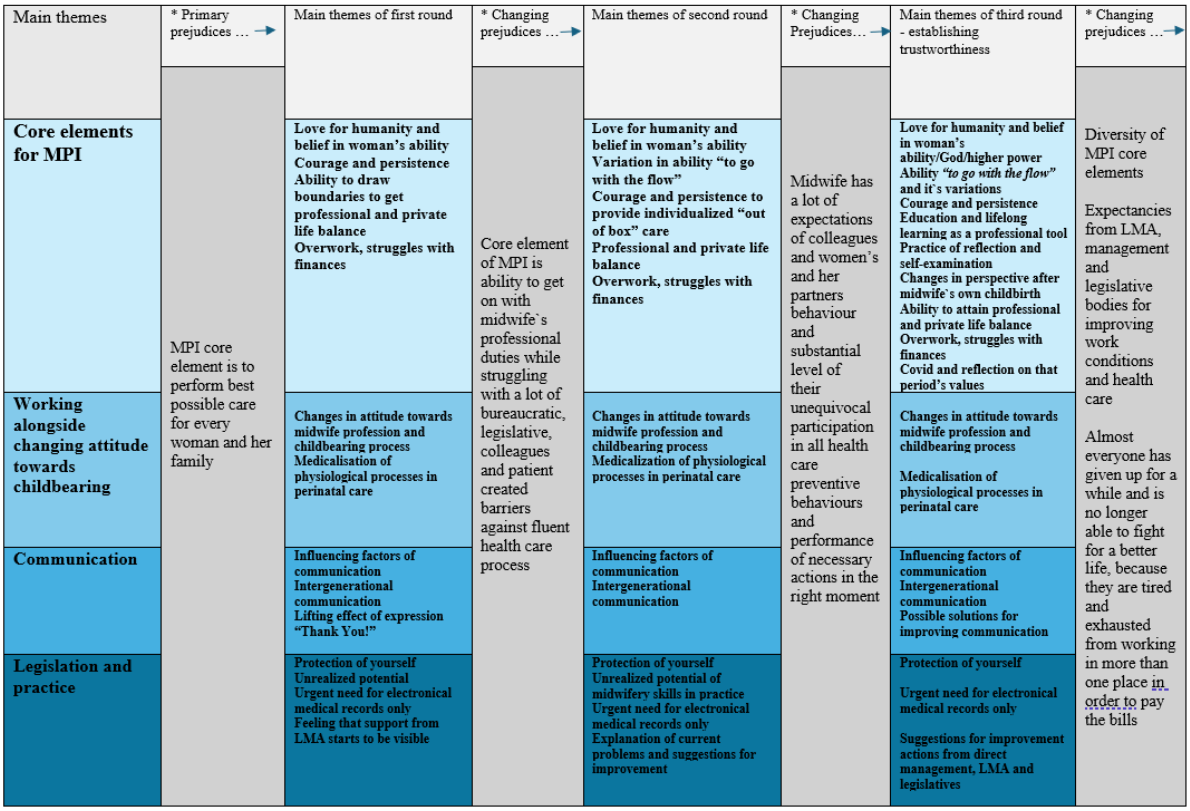
The following three themes were conceptualised as elements which intertwine with the core elements of a practicing midwife's professional identity:

2 Working alongside changing attitudes towards childbirth;

3 Communication;

4 Legislation and practice.

For each of the three rounds of interviews, initial thematic analysis was performed followed by continuous reflection regarding highlighted themes and my own self-reflective interview with the consultant midwife about my changing prejudices and preconceptions (See Figure 4.1 and Annexes 1, 2, 3).



* Work started with my own reflection about prejudices of MPI together with its concept studies in literature and contemplation on it. Discussion and reflection on changing prejudices were made before starting the first one and after each round of interviews.

Figure 4.1 **Findings – elements of practicing midwives perceived professional identity**

4.1 Theme 1: Core elements for a midwife's perceived professional identity

This first theme consists of the following subthemes, which arose as core elements in practicing midwives' current perception of their professional identity. In this theme midwives in all three interview rounds described in depth their perception of core elements of a midwife's professional identity from which following themes emerged:

- Love for humanity and belief in God / higher power and a woman's own ability as also in midwife's ability 'to go with the flow';
- Variation in the ability 'to go with the flow';
- Courage and persistence;
- Midwifery education and lifelong learning as a tool for support and help;
- Practice of reflection and self-examination;
- Changes in perspective after their own childbirth;
- Ability to draw boundaries and attain professional/private life balance;
- Look back at the Covid period and reflect on that period's values;
- Overwork and struggles with finances as core hindrance (see Annex 3).

Midwives also described their profession, to be able to be there at that special moment in time with the family, as a privilege. There were midwives who described their profession as something more than professional occupancy, but as specific way of life or calling. Necessary

tools for achieving these elements emerged: courage and persistence, gained education and professional experience, the practice of self-examination and the ability to draw boundaries. More challenging current elements of midwife's professional identity such as overwork and struggles with finances were also highlighted.

There was diversity in midwives' expressed thoughts concerning the core elements of their professional identity. The following question took midwives the longest to answer in all interviews. They had to stop, be quiet and think for little or for a moment longer, before answering.

Midwives described one of the core elements of a midwife's professional identity as the belief in both a women's power and the crucial need to be with her as much as needed.

Juniperus: "*Personally, a midwife is a person who is next to another person, in her important moment, but as much as she needs their help. I believe in her power, women's power. Because I never talk about midwifery in complicated births."*

Midwives expressed their belief that a midwife is a universal professional in the field of maternal and child health, who can do a lot providing healthcare for a woman and empowering and encouraging their family, but they lack ambitions to use all their professional competencies. Nevertheless, midwives admitted that they could actually do more than they currently do in practice.

Quercus: "A midwife is a very smart human being with so few ambitions…it is such a universal person who can do anything."[11]

The midwife's professional identity was described more as a lifestyle or a mission rather than as some components of a concept of professional identity. This was also an important moment for a midwife's professional identity when it was described as a very beautiful profession, but with significant burdens and challenges within it.

Ulmus: "The profession is extremely beautiful, but emotionally and even physically sometimes it is difficult to bear. Because being a midwife is difficult… it is more like a life challenge, not a profession."

There was also diversity when describing core elements in terms of the physiological and pathological processes in the childbearing process and the midwife's role in it. From this point of view, midwives described very different thought horizons. There were midwives who saw their main professional mission and being as providing care and enhancing a woman's ability to do as much as possible by herself within the care spectrum of physiological processes.

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[11] With three dots (…) in citations the pauses of silence that were necessary to think before responding are depicted.

There were also midwives who described how thrilled and positively exited they were in preventing and resolving pathological situations, especially when the work demanded quick reactions and precise action, despite the high energy and demand for experience that it required.

Betula: "It is a difficult profession also physically. I am a fan of active childbirth, there are colleagues who absolutely don't like it, but I've got it! You must have some midwifery experience, you cannot work without experience, there will be neither intuition, nor knowledge or wish to be here; in the rush and complete peace simultaneously, while performing duties in a pathological case."

Overall, this theme block showed how diverse midwives' thoughts are on the same issue: their professional identity. Although there were common themes, a single topic block could produce very different points of view. The midwife's limits of responsibility and expectations from others were described differently.

Hedera: "I like all things natural, that's what I like, I don't like medicine as such. I prefer birth without oxytocin, without stimulation, without running, without active birth… so that it just flows."

Midwives described the necessity of feeling when exactly and how much you are needed to be of core value as a midwife. A midwife should have the ability to distinguish how much she is really needed and not force herself upon another person, even with good intentions, which is not acceptable in this profession. A midwife is a professional who is near or beside someone and is trying to encourage and enable this person to do as much is possible by themselves.

Juniperus: "Midwife is a human who is next to another human at an important moment for that human…, but only as much as she needs her help."

Some midwives described the core of their professional identity as a mission in life rather than just a profession. From that came an acknowledgment that this was some kind of privilege or even one of life's opportunities for joy. Midwives described a core value of their professional identity as the opportunity to just be the midwife and to be with families in those special moments. The very fact of being a midwife is described as a value and is described not so much as a profession, but as a way of life.

Ulmus: "You understand that for this salary and for the opportunities that could be in medicine, you can work and do something else, but you don't go and work somewhere else. I really like my job and every time I go, well, most of the time I really go with a big smile on my face. And I don't know if I can love another job, because it's my way of life."

Juniperus: "I come to work, to be on duty – to get high. This is what I have always told students, because there you no longer think about work as such. You just go do your mission."

One of the described values in this concept of professional identity was intuition or a 6th sense, gained through years of practicing midwifery. This was described not only as value, but also as a necessary tool in a midwife's everyday practice and not as something able to be learned in the process of studying to become a midwife but gained through work experience and years of practice.

Quercus: "Well, that 6th sense develops and that kind of professional, I don't know, professional cretinism, professional experience…, call it what you want, but it's like you already know approximately one step ahead, what will happen next, if you do this or don't do that. I trust that intuition for sure."

Salix-alba: "My value is my experience, my knowledge. Nobody can take it away or do anything about it. Here it is and it is mine; it is my midwifery."

Creativity and openness to diversity were described as necessary norms in practicing midwifery. It was not only described in terms of an acceptance of different beliefs, orientations or nationalities, but also in being able to be open in totally different situations in childbearing healthcare models, and the ability to deal with the variations in resolving seemingly similar situations in different ways to care for a woman and her family. The midwives described the ability to bond with any kind of person or family, which is vitally necessary in daily practice.

Populus: "Probably the ability to read the situation. Every situation is different; therefore, it is very creative to perceive any situation and human and be able to connect in such a way, that will work best there."

There were midwives who described their belief in God as a core value in this profession. They even described this as main leading reference point which guided them in the midwifery profession in general. This basic idea resonates with those midwives who described the core value of their professional identity as a mission in this life. The unifying factor was the belief in a higher power and in being a midwife as a destiny.

Populus: "I believe in God. I am here sent to this world, to make this world better for one tiny little bit. And I believe it. And with that it is a sign of equality with midwifery as well: do not harm the patient – client in your work. I believe in women's innate ability… I have my conversations with God. It seems to me, more and more, that I start to understand it. And to explain it to others is not so easy."

Some midwives believe in the unborn child more than they believe in the woman herself. They base their faith in the child on the fact that the child does not know how to lie. They observe the child's movements, whether they are active or passive, the nature of their heartbeats, how they engage in birth and their growth pattern.

Thuja: "I think I even believe that child more than the woman. The child is always so open, so direct. They do not know how to lie, and here's the unborn, with him it's exactly the same; if he doesn't like something, either he doesn't lie physiologically, or he won't act in the way we expect him to do, or he won't have that right kind of heartbeat. Mother can do what she wants, but he will say how it really is."[12]

Overall midwives admitted that their profession is more than just that and characterised it more as a mission in their life or a lifestyle. From that perspective subthemes in core beliefs, norms and values are emerging: love for humanity, belief in God/higher power, a woman's own ability and a midwife's ability 'to go with the flow', the ever-present need for courage and persistence, a balance between professional and private life, issues of overwork and financial struggles.

4.1.1 Midwives' love for humanity, belief in God / higher power, and belief in women's own ability 'to go with the flow'

Midwives described their faith in a woman's ability to withstand childbirth by themselves as intertwined with a midwife's ability to provide the necessary care for a woman to withstand the process. A midwife should believe in herself and be positive about women's innate abilities. It is not just theoretical medicine and facts from health history that matter, but also the ability to make a person feel that she can manage and really encourage her.

Malus: "Perhaps the most important things: to believe in the woman, to believe in the midwife herself as a midwife. Well, whatever has been said, the more you work, the more you understand that it is the head, heart and hands. Well, even if according to the guidelines it seems that the woman won't give birth, but in your heart, you know that she will give birth. And she does."

Quercus: "I believe in myself and my intuition."

The belief that each woman can give birth with no additional medical assistance was not described as a blind or baseless belief. This ability is intertwined with another ability, to be able to assess professionally the possible risks to the health of both mother and child. This was a description of a midwife's professional ability to distinguish precisely her capability to provide physiological care during the childbearing process and to notice in time when such care is no longer in the interests of the mother and child.

Malus: "Well, I believe in God, that everything happens as it should. Women's ability, that she is able to do it by herself. Letting everything go so far, including a woman's wishes, as long as it does not contradict her own safety or the safety of the unborn child."

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[12] In Latvian language "newborn" is "he"

The midwife's belief in a woman's innate ability to endure the entire process of childbirth herself, with no medical interventions, was described as a value and norm necessary for everyday professional practice.

Cydonia: "I believe in the power of women. Well, if the woman is ready for all that herself. The midwife is a companion, that's all."

Midwives describe this as the ability 'to go with the flow' not only according to the woman as an individual. It is seen more broadly as within the context of the woman and her family and encompasses the necessity for empathy. The attitude towards a midwife's duties and performance was repeatedly described as: "Do it as you would wish it to be done to yourself."

Corylos: "Broadly speaking, the essence of a midwife is to be with the family, during pregnancy, childbirth and postpartum and to provide them with both physical, emotional and practical help. I always try to work the way I want to be treated. Well, in principle, I work according to the principle that I would like to be treated that way as well."

Midwives elaborated on the concept of "*love of humanity*" as not so easily achievable in everyday work life. It was described as a necessary quality of a midwife's professional identity, but midwives honestly admitted that in real life to be someone who accepts anybody was not so easy to achieve and required a lot of hard work with yourself.

Larix-mill: "Well, just imagine, you come into contact so much with the extreme limits of the other person during the birth process. And you have to really love people and want to help. To be a good midwife you have to be very accepting, which is probably the biggest problem. You must work on yourself a lot."

Midwives described the belief in a woman's innate ability to give birth as something simple at its core. They also explained that to practice this ability and to be a supportive midwife you need to be patient and calm at both at work and in your attitude towards childbearing itself.

Larix-mill: "All women can do it; it is your innate ability. Well, it's like in the intestines, everything must slide down. You must get it to the bottom and then you have to get on the pot and just push it out. Well, it's the same with a baby, you must wait for him to settle down and everything will be ready then. And you don't need to do anything special there. It is important not to complicate things unnecessarily; you just need to be patient and calm."

The ability *'to go with the flow'* contrasts starkly with the medicalisation of physiological processes in perinatal care. This ability is characterised more in the context of physiological birth than any birth: with or without medical interventions. The ability *'to go with the flow*' is characterised as the ability to manage the entire childbirth process without medical interventions, which are designed to manage this process actively.

Juniperus: "I like all things natural, I like, I don't like medicine as such. I like the most natural, but I also like it to be easier and better for a woman."

Some midwives characterised the ability *'to go with the flow'* as tightly and inextricably linked with faith in God and love for humanity. Belief in God allows them to trust that everything happens as it should, regardless of the easier or more difficult moments of life.

Hedera: "I believe in God. I believe that if he has already put me here, then this is my path to be a midwife here. I believe that everything happens as it is supposed to happen."

Populus: "I am not a typical specimen in this world. Yes, I tend to throw myself 100 % into everything and I do it as midwife. I'm a Christian, I've already said that. I love God very much I love him so much…I love to help women to get their experience, whatever it is. I feel like It's like a refreshing shower for me. You can always talk to Him and… and know that if something doesn't happen how you'd prefer, that life is not meant to be good, calm, harmonious all the time."

4.1.2 Variation in the ability *'to go with the flow'*

Midwives reflected honestly on the fact that their ability *'to go with the flow'* did not always live up to the trust placed in it. They see this ability as inextricably linked to a professional midwife's intuition, openly reflecting on the fact that even when they have sometimes been believing in it, the health result in childbirth process has been different.

Picea: "Simply, you either have intuition, or you haven't. Well, you either feel it or you don't. And sometimes you don't even feel it."

Midwives noted that even if they sometimes see that everything objectively is happening as it should in the birth process, there are times when they can no longer let things happen, as for example a woman starts to behave hysterically or no longer wants to take an active part in the birth of her child. In those moments midwives should stop and start to behave actively and do anything possible to galvanise the woman and motivate her to work. At this point a midwife can no longer indulge so much in this ability 'to go with the flow' and rely only on a woman's strength.

Syringa: "You really must… have such an inner trunk that we don't feel it too much. And it is also important that you, yes… you can speak with sweet words, but you must be such a psychologist when you understand that they are out of their powers. You need to gather together the woman, gather yourself and control the process."

Midwives reported that in birth units it is often not possible to follow this ability as they have several women to attend to in one shift. It is even difficult to manage with all the paperwork and medical manipulations and that they no longer have the time or energy left to listening to themselves and even try to use that professional ability.

Picea: "All the time you have to take care of things, about the unit and everything else, there is always something to think about, something to do, filling in the documents, putting i/v on… you can't just go with the flow, but sometimes you so want to."

Midwives described the mental exercise where you put yourself in another person shoes as a helpful kind of methodological tool for this ability. They described it as a 'helpful stop sign' before continuing with the woman's care.

Thuja: "I always put myself in her shoes. Well, let's say, if only I were in a woman's place – Would I want it that way? That's one. And the second – Would I like to be treated like that."

Midwives highlighted the need for acceptance of others and mutual respect as basic and core values of a midwife's professional identity and saw this as within the concept of love for humanity.

Tilia: "Courtesy to the patient, courtesy to colleagues, mutual respect. Accepting each other."

Midwives characterised their ability *'to go with the flow' as* not only necessary, but also as a rewarding part of participation in the process of a woman's transformation. This process is happening individually and very differently for each woman, so there is also need for previously-mentioned acceptance of others and their differences.

Hedera: "I like that a woman gets to overcome her fears and inabilities, and, in the end, she gets to experience how strong she is. Childbirth is a transformation for a woman, she transforms herself from a child to start becoming a mother, step by step. Each in their own period of time, one does it easier and faster, the other slowly, little by little."

A midwife's ability to be near, but yet invisible, so she can provide this process of *'going with flow',* with no unnecessary disturbance or intervention was highlighted as a necessary element of a midwife's professional identity. This *'being together'* with a woman was characterised as being silent and invisible. Midwives noted that this was one of their highly valued abilities and skills.

Hedera: "I know how to wait and be quite on the corner of the room, so as not to disturb."

Midwives honestly admitted that, by their own observation, younger midwives at the beginning of their career tended to provide this *'being together'* with women better and more often.

Juniperus: "They have changed, they have changed because, what I want to say, the young midwives are more sensitive, the young midwives are more willing to do something, change their postures and, let's say, participate more in the process. You could say that they want to participate, the old midwives are different: I came, I looked… they left, these young ones are the ones who work more with people, with the woman herself, who are more present in the wards and talk to them more. They are more present."

4.1.3 Courage and Persistence

Courage and persistence were seen as important in midwifery practice. Themes like; the fight for implementing 'skin to skin' contact and the 'golden hour' in every birth, the courage to distinguish your own borders of competence and the provision of intimacy in childbirth, emerged.

Midwives described how in their view they are able to manage perinatal care processes on their own, without additional orders from senior doctors. This goes together with the ability to give their opinion loudly and to fight for it. They did openly state, however, that when a midwife insists on her opinion it can also be disruptive at work.

Cerasus: "Persistence and the idea of what obstetrics should be, what midwifery should be, also helps, but it also gets in the way, it can, because sometimes you have to argue a lot with doctors if you don't agree with their decisions. Well, yes, I have such a character, I can argue with them, it can also be evaluated in two ways, both in terms of helping and hindering factors."

There were midwives who saw providing for a woman's needs in the childbearing process as a genuine legal fight in their everyday work. It was described as a difficult task, despite the education and experience they had gained. They talked about providing this defence as being tough. Their work did not just involve being together with a woman, but working really hard in her defence.

Malus: "I don't always succeed in this way, despite my long experience. Well, to be an advocate for the woman in birth, because a midwife is an advocate for the woman in birth."

Midwives elaborated honestly that courage is sometimes needed as much for the midwife, as for the woman giving birth. They noted the existence of stereotypes in one's own life about childbirth and how sometimes quite a lot of courage and persistence is needed firstly to persuade yourself as a midwife of the benefits of alternative care in some cases and how after you have persuaded yourself, the same work is required to persuade the woman.

Juniperus: "It is, however, the courage to persuade the client to give it a try. Even if it is not trendy or common."

Some midwives reflected on the fact that these days the biggest need for persistence is just to provide a birth without haste or rush during the process. That persistence is needed just for communication with other birth unit healthcare personnel to provide clarification and to justify a midwife's belief in the truth of the physiological process.

Hedera: "I like that women get the experience they hoped for. I believe that they can do it by themselves, I am in no rush. I don't like hastiness and medicalisation of birth. I can wait."

Midwives see the reason for this difficulty in acting as they would like as based in the hierarchical relationship between a midwife and a doctor at work: not all midwives often feel strong enough to object to a doctor's tactics. They noted that the older generation of midwives, in particular, objected less. They see the reason for this as the fact that they are already tired of fighting.

They also noted that after some fights younger midwives also give up as they lose professional belief in themselves.

Ulmus: "There are different aspects because they are like that, and don't do more than standards require, maybe they have already done their fights and want them no more, very often they are before retirement age. And then there's the other extreme, where it's the young girls who are very reserved when they're just afraid to say anything against doctors' orders, but most of the time, the new ones come with harder backbone than we originally came with, but they can be broken…, but when heal that backbone back, then you can start to fight for everything again. When you come in as young midwife with such big, big visions, big hopes, that we will be great specialists at least in physiology, but doctors tell you: "You are nothing." Then you kind of slow down."

Midwives generally characterised all practicing midwives as brave, in terms of working alongside practical challenges, changing societal attitudes and ever-changing guidelines and challenges to obstetrics itself.

Salix-alba: "The midwife is a very, very brave person."

Midwives with some decades of experience expressed their opinion that now is the most difficult period for midwives. They feel it is difficult to follow ever-changing guidelines and trends in society. They admit that changing their own professional already accepted norms to make them fit for new ones takes a lot of personal effort.

Juniperus: "It is very difficult. It is difficult to break that previous knowledge, stereotypes, to allow, or rather to say, to give in to that process. Well, let's give another step forward, so to say."

Midwives with several decades of professional experience also admitted that this work takes courage and persistence, not only to be able to believe and follow ever-changing guidelines, but also to be able accept changing trends concerning childbirth in society.

Sorbus: "If you don't have that courage, it will be difficult to do this work. It is very difficult to work as a midwife these days, that's how I would phrase it."

Midwives from the younger generation also admitted that even while studying to become a midwife they had had difficult times. Before their first real encounter with birth in practice they admitted that their prejudices were more glamorous about childbearing itself. They noted that in media it is sometimes much too glorified. After their first real experience in practice, they had to reflect seriously about whether they had the required courage and persistence to do this job.

Sorbus: "Because when I studied to be a midwife myself, I encountered the fact that my fellow students and I had very rosy impressions about childbirth as such. After the first childbirth we saw, there was, let's say… such a strong scaling of life, is that what a person would really want to do professionally all her life?"

Despite being widely spoken about since 2018, still some older colleagues do not implement *'skin to skin'* contact for at least for one hour in every birth (where are no complications). Midwives described how frustrating, time and energy consuming is to fight for those basic things in childbirth care.

Cydonia: "I hope that the whole old generation will slowly change, as well as the neonatal nurses, because there it is still a struggle, just for having undisturbed "skin to skin" contact for 2 hours. It's good that they don't put the newborn under the tap and don't wash him, it's still sometimes a struggle to forbid it, though!"

Courage was described as a necessary component of determining and applying the limits of their professional competence. Midwives talked about the necessity of being brave enough to admit both to herself and to colleagues in time that the help of other colleagues is also needed.

Quercus: "But there are situations when we still have to be careful but have courage at the same time and turn on our sixth sense, call it what you want, and evaluate, well, the situation what is in front of you."

Providing intimacy was another thing where courage and persistence are needed. As there are a lot of new healthcare professionals who need to have broader or narrower professional training in childbirth, sometimes women's basic need to not be disturbed during childbirth is becoming forgotten. It is at this point that a midwife is the one who should speak up and say "Stop!". It is important that only those to whom the woman has no objection are with her in the birthing room at this significant moment in her life.

Populus: "No, they also must learn, of course, yes, but I can say that quite concretely that there are limits for persons involved. I say: "Come with me, so you can come with me. If I have a student, then I have a student and one resident, that's all!" It bothers a woman when someone starts coming into the room without an invitation and doesn't introduce himself."

Midwives talked about their own need of courage and persistence in situations where the course of birth is not proceeding as the guidelines recommend. A midwife's professional experience and competence to lead physiological childbearing process tells her when in this individual case a different approach is needed. This goes hand in hand with a midwife's awareness that she should be responsible for her actions afterwards, whatever happens.

Tilia: "Not always you are able to do the work according to the guidelines, sometimes you should deviate off the course to achieve the goal… and you must also be ready to answer for it."

Midwives honestly talked about how recently a new issue where courage is needed has arisen. This particular problem is due to the fact that speaking Russian is forbidden in state institutions due to the political situation. A problem therefore arises if a woman speaks neither Latvian nor English. If a midwife wants to provide individualised care and has knowledge of the Russian language, she

needs the courage to use it in professional communication. Midwives described this in a wider context, as they do not see nationalities in birth, they see human beings and they tend to use whatever language they know, just to be able to provide woman-centred care.

Larix-mill: "If necessary, I speak Russian or English during the birth, because she has to have opportunity to give birth in her own language, I don't have to teach her Latvian now, it's their responsibility, how they live their life, but at that moment, it's like you have to leave that bit of personal conviction aside."

From my own reflective notes about the core elements of midwifery: "Midwife has always been expected to give more than just medical care. It was not always called holistic care, but that is what was expected from midwife, the definition of basic women's need in birth was known in 1970-ies (Ehrhardt, 2011), yet not in every country, of course:

- *To feel safe*
- *To 'turn off her thoughts'*
- *Silence or sounds she prefers*
- *Reduced lighting*
- *Heat/warmth*
- *Not being 'on stage' / intimacy*
- *No adrenaline.*

The decades pass on, but the same main things crop up as in the year 2000: (authors (Ayers-Gould, 2000) a stressed-out woman's need to have a nurturing environment in hospital establishments and a woman's need to have a spiritual connection with herself during birth. The midwife should be the professional who can provide this, in addition to medical care, of course, where needed.

And after half of century, we still talk about the same need for holistic and spiritual care during childbirth, which should be provided by midwife: "The care of the woman giving birth includes constant emotional, physical, spiritual, and psychosocial support and coping with labour pain," (Akbaş et al., 2022; WHO, 2018).

If it is so obvious, for decades, why we should still need to fight for it? It should be the norm in every intra natal healthcare setting.

(Self-reflection from 01.07.2024.)[13]

[13] Here and further in this Chapter, quotes are framed from my own notes of self-reflection and my own changing prejudices during the work on this Thesis (according to Gadamer`s hermeneutics described researchers work on their own changing prejudices as in work of Maxwell, C., Fleming, K. M., Fleming, V., & Porcellato, L. (2020). UK mothers' experiences of bottle refusal by their breastfed baby. *Maternal & Child Nutrition*, *16*(4), e13047. https://doi.org/https://doi.org/10.1111/mcn.13047) are inserted

4.1.4 Professional education and experience

Midwives described their knowledge, skills and competencies gained while studying to become a midwife and afterwards in lifelong education activities as necessary and helpful tools in everyday professional activities.

Cerasus: "First of all, perfect midwifery education helps, I am very proud how midwives are trained in our country. It also helps a lot that now most of the continuing education courses are set remotely and you can maintain your level of knowledge."

It was described how it is not possible ever to finish learning in a midwife's profession. No matter how long you work you must keep up with the latest developments in the industry and carry out self-education continuously. It was described as a necessary activity to prevent degradation in the professional sphere.

Cydonia: "Well, for you, you can never stand still. Well, live forever, learn forever, that's for sure. Because if you stop, you will start to go backwards."

Quercus: "Well, knowledge is definitely important to me. Because it can't be that I learn something and then I stop with that and I don't do anything for myself anymore, then I also automatically would stagnate, and I would not be able to give the best of myself."

Gained midwifery education was described also as a frame within which borders a midwife is allowed and capable to work. It is a frame that gives opportunities, provides safe borders and sometimes also indicates a midwife's professional limits.

Corylos: "Our professional framework is probably our educational level. And how can we say, there is no higher place for us, just within the midwifery profession. Of course, we can grow with many other things. Precisely in that field of academic education, but precisely as midwives we are, I think, in such a frame."

4.1.5 Practice of reflection and self-examination

This topic produced a wide range of answers and thoughts on it. There were midwives who practiced self-reflection, those who did it occasionally and those who admitted not to doing it at all. Midwives who admitted that they did not do it talked about huge workloads and being constantly busy. They admitted that it could be a useful thing to do, but that they do not practice it.

Aronia: "I'm not good at estimating myself..., it's not like I can see myself from the outside, maybe I'll have to start looking."

Cydonia: "I don't know from the outside, no, I don't think I try to look at myself. No, I'm trying to love myself more, but my life is a bit of a race at the moment."

There were midwives who admitted that they had been doing self-reflection only at the beginning in their carrier. It was described as the tool for looking for possible mistakes and reassuring themselves that they have not done harm to anybody.

Ribes vulgares: "At the very beginning, for about a few months, I wrote down all the time what I was doing, what I had done that day, that shift. And yes, it helped."

There were also midwives who admitted that they examine themselves only in cases with unsatisfactory outcomes. They mentioned that this is almost unavoidable after such cases and that it is in their heads for a shorter or longer time. They said it was like talking to themselves and reassuring themselves that they did the best they could.

Ulmus: "An internal experience, a terrible experience is for every time when outcome was not so good and that experience even hurts for a while, you can't say for how long. You feel that inner feeling and you always wonder if you did everything right and of course that you talk to yourself, then come to the conclusion that in terms of care and the help provided, it was adequate. And then the pain subsides at some point."

Some midwives admitted that the reason they did not reflect on themselves is the fact that it is hard to acknowledge mistakes or missteps and that they lack the courage to hear criticism unless it is constructive.

Corylos: "I think we don't look to ourselves because we can't handle criticism. I think maybe some part of us is trying to do that."

Midwives also talked about their need to practice self-reflection and to dedicate a substantial part of their time to it regularly. There could be variations in such practice: completely alone and undisturbed during her time off work, or during a short break within a shift. This would enable her to look at everything from a different angle. This would enable a midwife to provide the best possible care for a woman and her family.

Populus: "It is important for me to spend a little time with myself and have a drink and eat something. To look at it a bit from the outside, to rationalise."

There were different perspectives on self-reflection from midwives. There were some who do it regularly with the help of professionals in that sphere.

Larix-mill: "I've been through therapy. It took a lot of time and money for me to understand now that when a person wants or doesn't want something, it's not about me. The same about colleagues – your colleagues – it's about them, but it took me 15 years to understand that."

Some midwives honestly explained that self-reflection is too difficult and painful for them and that they do not do it and have no wish to do it in this part of their lives.

Picea: "It's very difficult for me to say that, well, I feel it very difficult to analyse myself. I can't."

Some midwives admitted that they do not do it and are in a kind of limbo status in their thoughts regarding its usefulness. They do not, however, reject it in theory.

Thuja: "I don't know if I would be ready to look at it all yet, I don't know."

Midwives also admitted that this profession in itself demands the ability to look at yourself. Some midwives noted that only after becoming a midwife, they started to practice self-reflection and that the practice of midwifery taught them how to do it.

Sorbus: "First and foremost, this job has taught me to look, let's say, at myself from the outside, the other side."

Midwives reflected also on possible reasons why every midwife does not practice self-reflection and even on it perhaps not being beneficial for every person. They were unified in thinking that the older generation of midwives, as any person from the older generation, has had a lot of psychological traumas from the Soviet era. Perhaps it may also be the case, as theory surmises, that it would be more harmful for some of them and no healing effect at all.

Larix-mill: "I think if we look at what previous generations went through in Soviet times, well there is no way to recover fully from it, if they start moving something, there will be definitely a nervous breakdown. Well, I mean, there are so many traumas layered on top of each other, that if you're at a certain age and start doing something for clarifying to yourself, it would be pretty crazy."

Some midwives noted that not everybody even practices self-reflection in the moments it is possible to implement it practically. A type of self-analysis tool could be added alongside the existing, obligatory, lifelong courses in communication.

Perscica: "It seems to me that every 5 years you must take a course about something, psychological, or communication, with colleagues, with patients. Some kind of self-analysis test or tool. Well, yes, you must think about it."

Some midwives described colleagues' inability to hear critical evaluation. Some midwives feel that constructive criticism has only recently started being used and that even now it is not always constructive in the workplace. For some critical evaluation is still something that equates to blame.

Tilia: "I think we don't look at ourselves because we can't handle criticism, that blaming."

From my own notes about talking with midwives about their perceived professional identity core elements:

"In some interviews it was like opening an old book from the beginning of 20th century, where some pages have never been opened before. So, you need to go and find your paperknife in some far corner of drawer or shelf, which also have not been used for some decades and carefully open those pages and look at them for the first time. You must

be very careful as this old paper smells so nice but is very fragile and is easy to tear. Movements to open those pages should be very slow, gentle, but precise. Then you have a revelation about what is written on them.

This was how it went in some dialogues with midwives, when those 'pages' about the core elements of a midwife's professional identity were opened for the first time."

(Self-reflection from 17.05.2024.)

4.1.6 Changes in perspective after midwife's own childbirth

This theme was not intentional to describe in this research about midwives perceived professional identity, but several midwives described their own childbirth as changing catalysator for their professional attitude. Some midwives noted that their approach and attitude to the practical tools for helping women during childbirth changed after giving birth to their own child. This included practical things they previously didn't think mattered or helped very much. Their own experience in childbirth afforded them additional understanding of the importance of various seemingly-small details.

Syringa: "Only after my birth did I become a different midwife. Childbirth softens you. Attitude changes towards seemingly-small practical and essentially helpful things, for example, when a male doctor comes into the birth room and says to you: "Well, why do you scream so much, does it really hurt that much?", "Well, why did you put a wet cloth on your head? Well, it doesn't help anything." And when you've been through childbirth yourself, you know that this wet cloth, and this scream helps you very much indeed!"

Midwives also noted a certain composure and peace while working after their own childbirth. Some described annoyance at the fact that senior colleagues had previously said that their professional perception would change after giving birth, but that they had not believed them. An additional ability to be empathetic was also noted and admitted that it has increased since their own childbirth experience.

Ulmus: "In general, after the birth of my children, I have become much calmer when doing my job. It's more fluid, I'm not worried about much. Before my own children were born, I really didn't like the sentence: "Oh, when you will give birth, you'll see," however, that empathy and that compassion for a woman is much more expressive after you give birth to your own children, because I would even say that you even feel more pain with her. And you know, how much they will love the child."

4.1.7 Ability to draw boundaries and attain professional/private life balance

When talking about the balance between professional and private life, several perspectives emerged: the ability to leave work at work and private life at home, the ability to draw an invisible line, with empathy, towards the women and family you care for, the ability to understand and remain firm that you cannot and should not try to do everything, the ability to understand and continue in the knowledge that a midwife is a human being with her own private life outside work and that this part of life takes time, the unfair ability to receive a maximum of 2 weeks' holiday during the summer when working in public healthcare and finally a look back at the Covid period and the core values regarding this balance during this time.

The ability to leave their work at work, not bringing it home in their thoughts, and their private life and thoughts at home, was described by midwives as a necessity. Keeping the professional and private parts of life totally separate was described as a healthy model of behaviour. Midwives who admitted being able to practice this balance admitted that this ability to separate those two parts of life did not came easily and that it took some years to achieve it.

Alder: "I try to keep in mind that no matter what kind of situations happen at home, definitely don't take that kind of bad feeling to work. Because the others are not guilty of anything, they should see me as a professional, – smiling and welcoming, not tired and grumpy."

Populus: "I can close the door when I leave work, maybe think about it a little sometime, of course. Over the years it's less and less. I'm able to switch off from work to what is my safe place, I have a safe place, it's my home."

The ability to draw, with empathy, an invisible line between the women and family you care for was a balance looked at from a different perspective. It was also described as the ability to perform a midwife's duties without giving away too much of yourself. As empathy is crucial in the midwifery profession it is not always easy to draw that line: "I am at work," Midwives sometimes tend to give and do everything they can when providing care for a woman and her family. The danger here is not only quick burn out, but also the disappearance of the authority of the midwife as a professional with the included duties and rights, at work.

Alnus: "What a midwife really needs is empathy. I must learn again not to be so overly empathetic. In this way, to protect yourself, don't let so much inward. And to teach how to somehow close the invisible door."

Padus: "I may have opened up too much to a patient at other times, as a bit too friendly and then that person is not considering me anymore as an authority. This is the mistake I should not make."

The ability to understand and hold to the idea that you cannot and should not try to do everything, was described as a healthy attitude towards the job you do. A midwife's ability to do her best in such a special time with a woman and her family, should be within healthy limits. A midwife should be able to share her duties and leave some of the work to other specialists with her in that unit or situation. Midwives described this need 'to do everything and do it perfectly as a very dangerous path possibly leading to burnout and serious health problems. Midwives reflected on the fact that the older generation of midwives was less keen on sharing their duties with others in the team and tended to work more than was considered a healthy and balanced amount today.

Quercus: "That's why I always remember that; if I will do all the work or if I will not do all the work – surely someone will come after me, after you, after all of us. And how long will that employer or boss, or call him whatever you want, remember you when you can no longer come to work for one reason or another. You won't earn all the money, you won't do all the work, and you can burn out very, very quickly."

Acer: *"The middle age of our midwives is going towards 50s, let's say that this generation does not know how to relax, does not know how to organise its life in such a way that there is more to it than work and something more significant, perhaps. And for many there, it's not even a financial issue, it's just that it's a habit. Well, that's what I notice."*

Sometimes it was described how important it was to understand and maintain the fact that a midwife is a human being with a private life outside work and that this part of life takes time. It was revealed that some midwives progress very quickly in their professional life, but for some it takes decades to really understand and practice it. This was described as a double-edged sword; work so much you are too tired to have any satisfaction in your private life and consequently this lack of satisfaction leads you to be too tired and jaded at work. Midwives also talked about how others in family then perceived them as women, mothers or grandmothers. Are they at home enough for the rest of the family to really experience them? Even when at home, are they fully present or just trying to get more sleep or rest and asking other family members to leave them alone.

Ribes vulgares: "I noticed it very quickly, that is, if you want to have a healthy limit in order to be a good specialist, because if you take more of those hours, you can give less of yourself to others as you are more tired. So, I kind of learned it right away that I won't be that person who will just kill herself at work and has a burn out."

Populus: "And I wouldn't want to be that woman, where grandchildren will look at me and think that this lady, we have seen her so rarely. I can't trust her with the affairs of my heart,

but I want to be a person to whom my children, grandchildren can trust the affairs of the heart, and that means I also have to spend time with them now."

Midwives described receiving no more than two weeks' summer holiday when working in the public healthcare system as unacceptable. They emphasised how difficult a midwife's job is and expressed their regret that management do not allow them to recuperate fully. This was an issue midwives talked about with indignation and anger, using long pauses with silence and sometimes tears.

Salix-alba: "That the shared 2-week vacation is also regrettable… Shared, yes; one 2-weeks in season, one 2-weeks out of season. It is abnormal, because midwives, however, I would like to say, are educated human beings and need proper length of time for rest and energy recovery."

There were midwives who admitted that even after several decades in this profession they had not learned how to draw a line between their work and private life and in particular how not to bring work home.

Juniperus: "When I have to go to bed, then the merry-go-round started in my head: maybe I needed to do this, maybe I needed to do that –, because I still can't separate myself from work. I am like a cow that ruminates."

Midwives expressed frequent concerns when talking about how not to bring their home life to work so as not to affect their professional performance as midwife and so that their private life and personal mood would not been seen or felt by service-receivers.

Syringa: "You cannot bring any of your problems from home to work. You can't be that person about who others are saying: "She's not in the mood, that's why she's behaving like that." No, as midwife, you must be neutral, helpful, but also firm, so you can gather the women together, when she cannot."

Those who reported managing to maintain that healthy balance, admitted that it did not come easily or quickly. For each interviewed midwife the exact number of years varied, but for all of them it took years firstly to understand how to manage it and thereafter to maintain it in daily life.

Picea: "Well, I've learned not to bring work home, it's not one hundred percent for me, of course, but at fairly large percentage I manage it. This is also the result of many years of analysis. After about 15 years, I needed a lot, really needed a lot."

Several midwives proposed regular holidays and travel as practical tools for maintaining such a balance. In this context, 'regular' refers to a frequency of every three to four months, which should be maintained at all times to enable a midwife to feel that she has a balance between her work and private life.

Picea: "Whatever happens, you need to take a vacation or go somewhere more often, then everything balances out, – every 3 months.

Midwives talked openly about the darker part of this profession, where after cases with bad health outcomes, they feel totally wiped out for long periods of time. This may be why some also proposed that every midwife should have a special hobby, something nothing to do with work or family, but just for themselves.

Ulmus: "Emotionally drains us up, those cases that are not so beautiful. Yes, it can be physically difficult also, as these emotions leave you out of your strengths for a long period."

Cydonia: "I think you need some kind of growth for yourself, you need some kind of hobby, something to do, something, I don't know, someone travels there, but do you do something outside, outside of those two things: work and home. To learn something, at least it is for me, because standing still is different and if you stand still, you go backwards as a person."

Experiences of midwife's ability to achieve balance between their professional and private life differed. There were midwives who felt that this was an individual issue and that nobody could teach it to anybody else. This should be person's own decision and practice.

Tilia: "I think it depends on the person how they can separate it. There are no guidelines like that or anything, ... Well, it depends on the person how much they can separate their work from their personal life."

There were other midwives who, having had their own painful experiences in this area, admitted that they always tried to warn younger colleagues not to make same mistakes. They tried to explain to younger midwives how there would always be time for work, but not so much for our loved ones and ourselves, and that burn out can happen very quickly.

Quercus: "I always remind my colleagues young girls that they are already running to work, running for practice, still studying, still wanting to live somewhere and so on, ... I always tell them, remember that it is very easy to burn out and it can be done very quickly. Sometimes it is very difficult to get balance, because the professional load is heavy."

Midwives admitted that this ability to maintain such a balance took them a considerable amount of time, measuring it in years, sometimes decades. They reflected that it was only after some considerable time struggling and being honest with themselves that they were able to admit to themselves that too much is too much. They mentioned that at the beginning it was hard to say "no" to extra shifts or contracts. Midwives enhanced this ability to maintain balance with the ability to say "no" to work.

Pyrus: "At the beginning, I was just ... I was working as many hours as I could, I was struggling a lot, but after a while I started to understand that this is not normal, but if comparing

to older colleagues, I realised it quite quickly. I didn't work for 30 years and then realised that maybe I should have been living my personal life also."

Another aspect of balance was described as an ability to draw a line when not at work, but technologies let service-users write to them. As this profession demands a lot of empathy and love for human beings, a midwife should be careful not to be used in selfish way by service-users. Midwives described it as an art to draw firm, but friendly borders with service-users at work and not to give it up, just to feel like a nice person.

Thuja: "And we are so sweet and so good. Now and then you cross the line that they start using you a little more than they should be. There are time limits for texting to me, I have a life, you know!... But *you want to be good, and you keep answering, answering..."*

From my own reflective notes about a midwifes possibilities to get boundaries between work and private life in modern era of 'constant contact ability':

Are all these technological possibilities a good thing? Yes, if you use them with wisdom. If you use voicemail, automatic replies, forwarded calls etc., possibilities are now endless. You should not be on the phone or texting 24/7, if you don't want to and there are tools to deal with this. Researchers described the phenomenon where technology could enable people to be more flexible at work, but at the same time it could also cause work – life interference, if not used wisely. (Findlay and Thompson, 2017).

It somehow recalls tales of ancient 'people and fire'. If you don't know how to use it, how to start it, where to let it burn so it is safe and warm and not destroying power, as it could burn everything down, but with proper use it could represent safety, convenience and be a great help for the further progress of humanity.

It seems that this possibility to consult with professionals 24/7 with the newest technological possibilities is the 'people and fire' of today.

(Self-reflection from 11.11.2023.)

4.1.8 Look back at Covid period and self-reflection during that period

It was not the intention to explore core values from the perspective of a look back at the Covid period in this Thesis, but midwives talked about it in the sense of a measure or tool for the core elements their professional identity. They looked back on it and talked about how it was very clear at that time what mattered most, how important your family, friends and those people closest to you are. Of most value was simply the possibility just to be with them even without the existence of any special occasion. The value of being in nature, by yourself or with those closest to you was very high at this time. They noted that now it somehow slips away in the daily pace of life.

Malus: "To a certain extent, I liked the time of Covid, when the desire was for something smaller and simpler, because then there was actually more going out to the sea, to nature, just walking along the shore here and there, doing nothing and not thinking."

From my own reflective notes about Covid period and basic values in that period and women's constantly heavier workload at home, compared to men:

"So, during Covid people were more aware of self-care and basic values in life. For example, there used to be so many more people in that period just walking along the roads and in the woods than there are now. People took care of themselves more; women and men were forced to divide the responsibilities of housework more. Is our memory so short? And why are women still working more at home, even having a full-time job? It seems like it was and always will be so. It can be read even in fifty-year-old articles (Eisenberg, 1975)! It is still happening and was also so visible during Covid. Could it be linked to woman's caring nature in general? Or is it more our traditional way of education in families, where a woman is the main person to provide care and nurturing (Docka-Filipek & Stone, 2021)? Do we really need Covid or some other cataclysm to make women to be more aware of their own basic needs and self-care?

It seems that caring for others is still not seen as hard work. It is interesting that society gave us voting rights more than 100 years ago, but women's work is still less highly valued and with lower reward[14]*. Is there a link – because midwives also admitted that during Covid they were more aware of simple self-care activities; walks in nature and breaks outdoors at work, etc. When will it be normal, if both partners (women and men) have full-time jobs, for them to share equally housework and childcare? Will it be after more cataclysms or it will take another 100 years?"*

(Self-reflection from 29.11.2023.)

4.1.9 Overwork and struggles with finances as core hindrance nowadays

In this theme block midwives pointed out three main issues: overwork being tightly bound to too little pay for the work they did, overwork and night shifts having a damaging effect on midwives' private lives and midwives being poorly paid leading to multi-tasking in several workplaces and endless rushing and exhaustion.

From midwives' point of view, overwork is inextricably linked to inadequate pay. None of the midwives who work in the public health sector would want to work more than 40 hours per week, but they still do it because their regular salary does not cover everyday expenses;

[14] Women in Latvia were granted the right to vote in 1917. This right was first exercised in the 1920 Constituent Assembly elections.

grocery bills, rent, fuel and children's education costs. Midwives talked not only about the necessity to be able to pay the bills, but also about the feeling that there is paradox between how much is required of midwives in terms of education and professional competences and how absurdly little their work is financially valued.

Salix-alba: "... but you know, people from such a profession also want to eat every day. Yes, it's terrible! I would not do my job better if I get paid more. Certainly not, and I also worked for much less money, several years ago and I tried to work with the best conscience, that's not about that, but it's a question of how well you can organise your everyday life outside of work. It's do you have somewhere to come home? How warm is your house? How do you get home? What on/with do you get home? How can she give all her empathy, leave that house at home and work at work if she gets pennies. She does not even have a chance to go to a psychotherapist. Well, I don't need to tell you these things, it's terrible! For an educated, intelligent person, it is very difficult to work for such a little money and feel absolutely not appreciated. This is very serious. This section is very serious."

Overwork and night shifts have a damaging effect on midwives' private lives. Midwives explained that working at the weekend at night and overtime is not their choice, but the only way to earn more money, because not everyone is ready to go to individual birth-care contracts and be on the phone 24/7.[15] Midwives want to be with their families and have a certain amount of time off work. New midwives with short work experience talked about midwives with longer work experience warning them about the damaging effect on family life of night shifts and overwork. The destructive effect of night shifts on private life and the additional stress during night shifts, when colleagues and other specialists are not always available due to a lack of personnel at night shift compared to during the day, were explained. Children, however, as all midwives know, often choose their time of birth to be at night.

Cerasus: *"Sometimes those 160 h turn into more than 200 h. Of course, salary plays a big role here, if I received the amount I would like, then of course I wouldn't count the hours, how many hours I spend at work per month and how much I get in personal life, it would be less work at night and on holidays, but when you want to earn, then you choose those days, those nights."*

Alnus: *"Those nights, well, older colleagues have always said to me: "You don't need to work at night, look, none of us is above normal; no family anymore, everyone's husband has gone somewhere." Of course, my husband doesn't like it other times, but yes, ideally, I would like only day shifts and no nights and weekends, because I have a baby. Those working holidays*

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[15] In Latvia perinatal health care is free of charge, but it is still possible to have a contract with an individual midwife for individual birth-care contracts. Homebirth is available only in the private sector.

mess up the plans quite a bit. Of course, also in terms of health, nights and stress, but for me to work in a small department, it's even more tiring, because somebody is cut off all the time, because of the money issues. There is no more nurse on duty at night. You're alone, because the doctor is somewhere at home, then you simply answer for the whole unit. And live like on an edge of knife and you never know what could happen!"

Midwives elaborated clearly on the issue of such poorly-paid midwifery services leading to multi-tasking in several workplaces and endless rushing and exhaustion. There is an absurd situation in the public midwifery sector, where even after shifts as long as 24 hours in a hospital ward a midwife does not go home, but to her second job. Usually at some private practice or as an assistant to gynaecologist in outpatient clinic. This leads to exhaustion and sometimes rushing from one job to another, just to have the chance to get at least a small moment of rest. This, in turn, sometimes leads to an unnecessary rush of physiological processes or an inability to be patient enough during childbirth care.

Philadelphus: "I can probably say that I don't like the rush, because there are people who work 3 jobs and they always want to get faster with birth process, just to have a brake. And there is a great hurry, or it is done according to one's own convenience."

Cydonia: "The salary is definitely too low, because then I probably wouldn't work in a second job. The salary should be definitely higher!"

Even while admitting that working in more than one workplace or working full time and taking on additional individual contracts has a damaging effect on work performance, midwives do not currently see an alternative. How else to survive and manage regular everyday payments? Midwives link the issue of overwork to that of low pay for midwives in the country. They all stated that those who do shift work at hospital, would never also take individual birth care contracts, if they had a decent salary. They felt not only overworked, but also guilty regarding their families, as every day of their life is spent in the hospital shifts, in work with contracts and after all that they need a lot of sleep and so nothing, neither time nor energy, is left for family. They feel that they are raising their children 'by phone'.

Thuja: "Family is already suffering abnormally, but I need contract money to raise my kids. Well, that's terrible! You are rising your kids on phone: "Child, you're there? Yes, there. Well, then you go there, get your sister, etc.," that's how it is… Well, what balance are we talking about here, it's unbalance!... Well, if we assume, very clear and straight talking about it, if we were talking about €2,000 a month, well, you would not have to go around the world with these contracts and being on call for 24/7. If you can just do your shift with quality, go home and enjoy life with children."

Ulmus: "I'm not in favour of contracts, I only take them for profit, that's all, and I think 99 % of midwives would not take them, if the salary were decent. Everybody knows that!"

Midwives calculated what they could spend from their regular salary, concluding that it was impossible to live on that salary alone.

Picea: "Well, basically, it's just for getting to the grocery store a few times – you don't get to go anywhere else. Well, of course, payments yes, …loans and that is it in general. No, you definitely need to think about it…, very sloppy, very depressing situation."

Midwives reflected on how they felt that in general people in this country worked too much. They felt that midwives themselves worked too much and definitely do too much for nothing. They reflected that they sometimes did not ask money for a consultation with a woman or her family due to that feeling that being a midwife is a mission or way of life. They also admitted that was sometimes hard to ask money for a job done.

Populus: "The general question is, why have we overworked? That's good, that's a very good question. We cannot stop working. Do people in the world also work that much? … but I think that people in Latvia work a lot..., you are spinning around here like some kind of mystic creature, and you can't understand even why. Yes, and you start doing a lot of things for free, and then at one point you realise – no, but maybe you shouldn't do it like that, if you want this, if you want something else, but then again… that sense of mission in your heart."

Overall, midwives described the fact that they and their colleagues were often exhausted from running between jobs as a severe problem, not only for themselves, but also for patients. They also felt that their work was not appreciated on the part of the government.

Thuja: "I look at them, well, they have caught several jobs. And then they are tired from running from one job and driving to another job. The state does nothing; I think they do nothing! A plumber earns €24 for 28 minutes work. How much do I earn?"

Midwives expressed their regret and anger about the management reaction to their complaints for unacceptably low pay. Midwives regrettably noted the fact that currently midwives are paid the same as uneducated workers in a grocery store.

Tilia: "It's low pay, because we're on the same level as xxx cashiers. Unfortunately… And how we are chanted at our xxx hospital, that we already have salary above the average in the country and therefore we are not entitled to a salary supplement, because we already receive more than others. Nonsense!"

Midwives who also performed outpatient clinic work expressed their horror at the amount prescribed by the NHS for payment to midwives. They linked this and the previously-mentioned low salary with overwork. Their view was that the regular payment was so low and their financial need so pressing that they had no option, but to work in several

places or do shift work and take on private contracts. Another issue highlighted was the situation where duties carried out by a midwife were recorded 'on paper' under a doctor's name as the NHS pays more to a healthcare facility for this than for a midwife's work. This results in the midwife's actual work not being fully recorded and recognised statistically.

Pyrus: "When it comes to salary, we are not fully evaluated. Imagine, for all my month's work with pregnant women, consultations, I can receive 600 Euros from NHS at the end of the month, is this normal?! Understandable why the hospital wants the coupons to be written in the names of doctors. Bad, really bad!"

Midwives also highlighted another issue concerning overwork. As they saw it, a woman's ability to withstand childbirth is diminishing, leading to much more work for a midwife to do. More motivation and encouragement is needed, but there are no 1:1 birth-care units. Midwives admitted that they feel that they should also step back and think about themselves sometimes as they are not able to motivate and encourage women to work by themselves for 3 or 4 births in a row during one shift.

Cydonia: "I have now also started to realise at some point when there is some kind of limit and where I take a step back myself, because in the end it is a person's birth, not mine. If I can't change her opinion, I should keep up the strength for the next one as well."

4.2 II Theme – Working alongside changing attitudes towards childbirth

The midwives expressed a lot of emotion while elaborating on this topic. There were interviews where no questions were needed because the midwives, often emotionally, expressed their opinion by themselves. There were subthemes which arose more in a particular round of the three interviews, but in the overall analysis of the transcripts, all the themes described below ran through this theme block. The following subthemes were distinguished:

- changing attitudes to midwifery in society and among midwives themselves;
- disappointment in underestimation of the midwife's profession;
- changing social trends concerning childbirth;
- changes in women's ability to withstand the pregnancy and birth process;
- medicalisation of physiological processes in perinatal care;
    - the wish expressed by midwives for more media coverage of their attitude towards
    - the medicalisation of childbirth;
- varying awareness and attitudes towards current guidelines (see Annex 3).

Consequently, in this theme two main themes with subthemes were established: changing attitudes in society and among midwifes themselves and the medicalisation of physiological processes in perinatal care.

Overall, midwives admitted that theoretically they ought to work within the attitudes and value system of the family, but that it was not easy to achieve this in practice, as a midwife's professional judgement could sometimes be at odds with one of the family's beliefs. There are situations where it is challenging for a midwife to see that woman's lifestyle or choices, in a midwife's view, are not healthy for the foetus or newborn child and where sometimes even the child itself is not welcome in the family at all.

Larix-mill:" I try to work in the value system of each family. Well, the birth is not a re-education institution, you won't change people's views, you can only accept them and help within its limits."

From my own reflective notes about situations when the value systems of the midwife and the family are opposing:

"Midwives would wish that every expected child is a joy for a family, but in reality, it could be so very different. Children who are expected in their families tend make this occupation so beautiful and full of joy, but for some women it is a burden and, as research shows, even a financial, career and employment disaster (Nic, 2016).

This demands the ability for midwives to work not only within a family's health or lifestyle choices, but also within their overall value systems. They should be able to give holistic care in practice, so every women and family gets care within their world view, as long as it is not harmful for mother or child (Ayers-Gould, 2000).

This ability takes on something of the ability of the chameleon to change its colours. As working within every family's value system demands so much from a midwife: how she talks (chosen words and conversation style, amount of information, body language etc.), how much family needs or does not need her presence, what kind of care plan a family expects … And as with a chameleon, family can see the midwife's so-called "chameleon colour" at the moment, but they should not feel those moments when/if her own values and attitudes contradict the family's."

(Self-reflection from 03.12.2023.)

4.2.1 Changing attitudes to midwifery in society and among midwives themselves

Midwives admitted that over the last two decades, the field of midwifery has undergone a complete transformation, shifting its focus from safe medical interventions to providing respectful care and using medical interventions only when necessary.

Salix-alba: Midwives have certainly changed, because times have changed, society has changed, the approach has changed, let's say, the attitude towards patients, towards people as such, ... Now we don't just teach some medical things, as it was in the 90s, but we learn a lot, both; through self-study and in compulsory courses, let's say psychological things, communication things."

Midwives openly admitted that they understood that their wish to be recognised or praised by others should not be a motivator either for change or to do more, but they also admitted that this need of appreciation was still somewhere inside them.

Pyrus: "Inside, you want that challenge, you understand that you are more capable than maybe society thinks. Because I understand this, and I could do this on my own, but you are also purely psychologically waiting for the recognition that you do more than others, but it shouldn't be like that, you know, yes... it shouldn't."

Disappointment in the underestimation of the midwifery profession

Midwives value themselves more highly than society values them. At a time when midwives have Bachelor's and Master's degrees in healthcare, they do not understand why they are still not recognised as independent healthcare professionals, but rather as people who can be ordered about by others in the medical profession. They do not feel that they should be ordered about, as they are aware of their abilities and professional competence.

Cerasus: "However, it will probably take many more years for the profession of midwives to be appreciated as it should be. I'm really tired of being called "the average medical person", despite how educated midwives are now and despite all the degrees that midwives get, as "the average medical person", it still remains in thoughts of other colleagues."

They also feel underestimated by society. With such a wide variety of information about childbirth currently available, almost every service user has their own view of it, forgetting that a midwife is a professional in the field. Midwives talked about how they are not servants, there to fulfil every service user's wishes, but highly-skilled and knowledgeable healthcare providers.

Ulmus:" Well then, currently working as a midwife is much more difficult than you can even imagine. The burden of society that everyone expects from a midwife is so huge. And mostly quite inadequate, at least when working in an inpatient facility, because a person feels that he will receive also spiritual presence and support from the midwife. Which we also do, it is undeniable, but unfortunately sometimes they forget that you are a medical person, and you control all these situations very well, you know them quite well. You've studied and practiced long enough, and yes, that assessment from people is not what you'd expect to hear about a midwife."

Midwives talked about how they were underestimated and unrewarded financially with long pauses and frequent tears. Midwives are indispensable and everyone, whether that is healthcare institutions, society or the government, expects a high level of professional responsibility from them, but this is in no way reflected in the meagre salary of a midwife. Midwives see as a paradox the fact that people expect midwives to have such an elevated attitude and sense of responsibility towards their work performance, but at the same time are confused about midwives' demands for remuneration.

Ribes vulgares: "Salary is an important issue at the moment, because you need to know how much you will get in this profession, doing your beautiful work. Nowadays people tell it to your face that you chose this profession yourself and that's why your salary is like that, and you can't want it to be more, because you're just a midwife… You have to know that you will never earn as much as an IT specialist."

Midwives repeatedly expressed their disappointment and regret and that in terms of salary they are valued as people on the same level as people in services where no previous education is required. This resentment lies in the fact that they had previously invested work in self-education, experience. The extremely high level of responsibility for the health and life of human beings is not appreciated at all. This also leads to some midwives not being seen as people who are valued healthcare professionals even at home in their families; because they do not earn a considerable amount of money, their partners see their profession, that of a midwife, as merely a hobby.

Salix-alba: "And when you see injustices, for example, about how much a babysitter, manicurist gets or how much a doula gets, where there is no qualified medical worker at all, well, bye! Just shoot me! Why am I educating myself at all, for what? My husband says: "How much longer will you go to your hobby?"… Hobby, that drive you simply to the grave."

Midwives see the remuneration system as distorted and feel that it is not worth investing in improving their academic education because it is not reflected in performance evaluation in perinatal care. The system does not provide for a stable salary increase relating to their level of education. Only healthcare facilities themselves can offer such supplements voluntarily.

Quercus: "Even so, it is quite important that a person aspires to something higher and grows, and wants to do something, because at the moment it is like a midwife with a Master's degree. Well, well, if she has it, she can become a manager, – okay, her salary will be higher, but if she doesn't become a manager, then there will be no added value for that Master's degree."

Midwives do not feel needed due to both the management's attitude and the lack of adequate remuneration. This goes hand in hand with the attitude of gynaecologists, where cooperation and a professional opinion are theoretically required, but in reality, the midwife is

not considered an equal professional colleague. This also leads to midwives underestimating themselves; since management, doctors and society do not see them as independent and honourable professionals, they no longer see themselves that way either.

Quercus: "I will say this, I would say that we are not appreciated, but more so we don't appreciate ourselves and allow ourselves to be treated that way. We allow management to talk to us like that, we allow gynaecologists to command us."

The only reason why midwives still feel needed at work are the women and their families themselves. There is no appreciation of their work by management or state leadership, but there are still service receivers who need them. Midwives simply do not understand why they have not received decent salaries for so long, or why there are so few of them in the country. In this case, for state leadership money should not be a problem.

Salix-alba: "And we are so few in Latvia in general, we midwives are so few…maybe almost 300 of us. And we are still fragmented, respectively and in general such a doomed profession, I'm sorry. What are midwives still holding on to? To the fact that patients need us, but our state leadership absolutely does not. I have nothing more to add."

Midwives admitted that they were alarmed by the fact that several colleagues are leaving midwifery because they feel disappointed by the reality of the profession. Because they still value this profession, they have heavy heart about what is happening.

Cydonia: "Well, that's really a pity for me, because yes, we already have a third or fourth midwife who is leaving her job here in xxx, that's a real pity."

There were also some midwives who noted that they had lost their belief in this profession and its future and that they were currently at a crossroads considering whether or not to continue. They openly reflected that they felt in their heart this was a prestigious profession, but that the salary suggested otherwise.

Corylos: "Let's take into account that I believe that the work of a midwife is prestigious, it cannot be compared with any work done by people without education and experience. It's such a low pay, because we're on the same level as grocery store cashiers!... Unfortunately. How can we look in the mirror."

Midwives also admitted that at the start of their professional career they had done a lot of extra unpaid work without any encouragement. After some years they had stopped believing in positive changes and had now lost their faith in midwifery altogether.

Cerasus: "I initially had hopes and did and organised a lot myself... now I understand that for at least ten years nothing will change here, and we will not be appreciated and will not be allowed to work normally. All the time some bureaucratic obstacles from NHS payments or laws. I am disappointed in midwifery; I don't see anything good here anymore."

Overall, this theme was linked with what midwives considered to be extremely low pay. They could not comprehend why professionals with such a huge demand for competence and responsibility, with the commensurate additional, obligatory educational activity could be valued so little by both management and government.

Salix-alba: "We are in a complete ass, pardon the expression, in a complete pit of shit! It's just kind of crazy! The responsibilities are huge, the responsibility is abnormally high, but the salary and attitude from management and society in general… Well, what are we talking about here anyway! If the country values me as much as the store cashier. And they say publicly that everything is fine with us… I don't know, everything is bad, a pit of mud."

Changing social trends in childbirth

Midwives elaborated on shift in recent decade in parents' emotional expressions in the birth room both during birth and in the first minutes after a baby had been born. They noticed that currently it is politer and somehow calmer than in previous decades, when there were louder expressions from women giving birth and more happy cries of joy immediately afterwards, even dancing and hugging from birth partners immediately after their baby has been born. Midwives with experience from the last few decades elaborated on changes in people's joyful reaction in the birthing room straight after birth. It was described how in previous decades reactions had been more open and not so self-censored or influenced by current trends of so-called appropriate behaviour. People in the past rejoiced more loudly and emotionally with hugs and kisses not only amongst themselves, but also with personnel. With the newest social trends and discussions about acceptable and unacceptable social behaviour, joy also somehow had been censored.

Ulmus: "Society has changed a lot, society as well as the profession of midwifery. I even would say that ten years ago people were much more emotionally open, they wanted to share their joy with others more. Someone could hug you in the birthing room and give you a kiss. It is much less common nowadays. People tend to keep their joy to themselves."

Midwives talked about their ambivalent attitude towards women who give birth with wild emotional expressions, like spitting, roaring, kicking, cursing and socially unacceptable behaviour. They admitted that it was hard to work with a woman who does not allow anybody in the hospital to sleep because she was so loud. At the same time midwives admitted that those, they called them 'wild women' usually gave birth fairly quickly and easily from a purely medical point of view. It is as if this wild behaviour allows the birthing process to go easily and without obstacles; hormones are working perfectly because there is no censure in a woman's

head. Midwives also noted that currently these so-called 'wild' cases are becoming less and less frequent.

Ribes vulgares: "When you can't find contact and the woman is very uninvolved, just let that woman give birth, as she has assumed it in her mind, you are there for her. And let her do it as she wants, sometimes with spits and rude rant, those wild cases. Thank God they are much rarer nowadays! Yes, it used to be more common, but society is changing, but there is one thing – those wild women generally give birth very well, because they don't pay attention to anything. They push when she wants to push, she breathes how she wants to breathe. They sometimes over breathe and vomit. And she's dizzy, then she's yelling about it…, but the birth itself is going on pretty well."

Midwives mentioned several branches of the newest trends which they have observed in society: the need for a similar, or even identical, in means of beauty, birth experience, communication via texts, the tendency towards the diminishing of woman's innate childbearing ability by media and consequent genuine decline in a woman's innate childbearing ability and finally the unwillingness to take responsibility for one's own health. Midwives stressed that a woman and her family's expectations tend to be more unrealistic these days. As midwives see it, this is partly because of birth stories in media which are posted having been corrected and made to look rosier and more beautiful than in real life and partly because of people's overall need, partly encouraged by media, to be beautiful in a standardised way.

Malus: "People nowadays want everything to be standardised; the same teeth, the same eyebrows and everything. So, they want the same beautiful birth experience just like others in social media."

Midwives described how they feel alarmed by a tendency not to talk with the midwife, but to text instead. This means that they sometimes even receive no feedback at all while the family is in hospital, but only afterwards read some unpleasant comments in media.

Larix-mill: "Tell me to my face, not behind my back, because then I won't learn, and I won't be able to change anything."

Syringa: "And why are there women who don't say "thank you"? The saddest thing is when you don't get that feedback, that gratitude, because it's one thing when you come to work only you don't know how to make money, but when you go to work full of some positive emotions, ready to help, take action, and that person doesn't appreciate it. Then something is a little bit missing."

The tendency towards the diminishing of a woman's innate childbearing ability by media and the consequent diminishing of woman's innate childbearing ability in real life was described by midwives as disturbing. They still believe in a woman's innate ability and see

the growing number of pathological births as a consequence of the media-proposed view that the childbirth process is something that should be treated.

Larix-mill: "Field of information is so saturated right now with the information about complications, that it awakes in women concerns that she might not be able to do all that. Well, if it wasn't so full of such information, she probably wouldn't even think that there is possibility for not to be able to give birth naturally at all."

Midwives elaborated on the observation that people in general are far more anxious and worried about their first newborn child than parents were just ten years ago.

Salix-alba: "Families have changed their relationships not only with themselves, with each other, but also with their children, they have become much, let's say, more anxious."

Midwives reflected that they see fewer and fewer women who are just admitted and happily give birth. They described it as the consequences of propaganda for women that suggests they are not capable withstanding childbirth without a considerable number of medical interventions. There are more women, in their view, who are complaining constantly about the pain, tiredness and slow pace of the birth process. There is far less joy in the birth of the new child and more complaints about how unbearable the birth process is.

Populus: "I notice so much that already during the admission process, women are verbalising their even tiny feeling of discomfort or pain, all the time. They don't want to experience and survive this process as much as in previous years: "I have a pain there, did I have a pain there, oh my God, how did my back hurt!", well they verbalise it all the time and comment on it. … And the baby is born, and that person doesn't say anything, she doesn't cry from happiness, she doesn't rejoice at all, but she already starts commenting and complaining, what is again bad and wrong, what is painful again, so everything is bad again, …it just continues. Which makes me also, I have to say, careful again, because in this way I must live and work with the fact that it will be like this in the future."

From self-reflection about current attitudes toward pain:

"It is not unique process here; media don't describe pain as something natural during birth, but rather as something that should be avoided.

Eight years ago, in research involving Dutch midwives, it was noted that: "Midwives felt challenged by the need to balance their professional attitude towards normal birth and labour pain, which favours working with pain, with the shift in society towards a wider acceptance of pharmacological pain management during birth," (Klomp et al., 2016).

Is this really driven by a woman's choice or just something that is available and should therefore be tried or used?

These are not the only changes that will come and will be becoming the norm. Virtual reality has even been tried as a method for reducing birth pain (Massov et al., 2024).

This just shows that there will constantly be changes in how birth will happen and be managed by women's wishes. This and other new things will become new norms and there will be renewed demand for midwives to have the ability 'to go with the flow'.

This flow should be from a woman's perspective, and a midwife should be able to always follow it, however different it may be from her own, of course from within the boundaries of the woman's and the child's safety.

A midwife could be imagined as a skilled rower of a boat, where the boat is the care during the childbirth process. Like a boat on a river, there are sections where a current could be fast and with rapids and dangerous stones and sunken trees not always seen from above the water, all of which require timely and skilful manoeuvring; there are sections with a good current carrying the boat forward, where midwife can just sit, observe and enjoy the sight and then there are sections with almost no current at all, like in a pond, and the midwife has to row hard to keep the boat moving forwards.

This flow is every changing and midwives should adjust to it. It should not be defined as something unalterable in her profession.

(Self-reflection from 05.06.2024.)

Midwives noted that, overall, the responsibility of the whole family is diminishing. They noted that people are listening to lots of podcasts and taking many courses, and that midwives feel that people need more instructions rather than conversations with them. The idea that responsibility for the child lies with the family rather than health professionals is somehow slipping away. Midwives say that they are seeing fewer and fewer young families who listen to themselves and their own beliefs; they somehow do not want to take responsibility and make choices but want more instructions.

Salix-alba: "I have come across women who have gone through pregnancy, they are ready to be pregnant, but they are absolutely not ready to give birth. No, there is no such stage in the head that it has to be completed in some way, that the process will end someday."

Larix-mill: "You must take responsibility yourself, you can also go to the hospital, you could not go to the induction, you can refuse. You can look for alternative ways, you don't have to be like sheep. Well, it's your body, your child and you will have to choose where he will go to kindergarten, what vaccinations to give him or not, to which school he will go etc. …Well then at every step you will have that responsibility and you will have to choose; do it according to fashion or do you do it according to what you believe. I always say when a child is born,

there are no instructions tied to their feet. Watch, listen to all the tips, try and accept what you like best."

Midwives see these changes as somewhat alarming. The first of these alarming changes concerns the glorified and glamourised stories about childbirth itself presented on social media. Midwives explain that, in their view, maybe this is the source of such unfounded and unrealistic expectations from parents of how it will be when they come into a birth unit for their own child. The second issue midwives mentioned was concern regarding the manner of service users' communication. They explained that they did not feel treated as human beings by service receivers. This was because they preferred texting to real conversation and had no boundaries. They could text a midwife at any time of the week, day or night and expect an answer right away.

Pyrus: "In my opinion, people's expectations of medicine in general, not just obstetrics, are completely unfounded. I don't know where they come from. Because often their desires are completely impossible. The person themselves does not understand what is happening here. I think it's because the field of information is so huge. And it is full of fake specialists in that field, who are not really specialists at all, but are quite active in spreading their propaganda there. And all those 20-year-olds grew up in a completely different world, they are much more childlike, and they do not take responsibility for their own health. And they do not really understand the boundaries in communication; they can send you a WhatsApp message at 10:00 pm and expect you to answer right away. No, they expect to be told what to do and do not take responsibility for themselves and blame everyone else afterwards."

Midwives noted that they see this overflow of information also as the one possible cause for higher anxiety among new parents or parents to be. Because people have access to all kinds of information and there is that old expression in media: "Good news is bad news", people are prey to a lot of alarming information. Adding to that, as people tend to live just within two generations under the same roof, they do not have continuous access to the help and wise advice from the older generation because they live separately.

Sorbus: "The relationships of families have changed, not only with themselves, with each other, but also with children, they have become more, shall we say, more anxious, perhaps. They are more interested in what could happen, more child-oriented, which I think follows from each other. The anxiety about the child leads to the worry about: whether I will be able to take care of that newborn, am I a good enough mother, do I have enough milk, do I have it all etc.? The media is full of information about complications. It's hard to imagine that 30 years ago, they would have such questions, they knew they had to do it, and they did it… And we don't live together in large families anymore, with several generations together, where you could see all

of this in its natural habitat from early childhood and receive wise advice or practical help from the elderly 24/7."

From self-reflection notes about the overflow of different kinds (in terms of quality) of media in the field of childbirth:

"The internet has given us opportunities that we could never have imagined before, and modestly speaking, it is a great help in every field of our life. But sometimes, it reminds me of the Tower of Babel.[16] *As humanity we have had our Flood in the last century, by means of revolutions, wars and all horrors that go along with them. So, the pride in creating and using the internet could be our Tower of Babel, nowadays. It is the pride of recent science inventions and was created for humanity to be united in one information field and to thrive and be proud of it, but it is also full of dangerous challenges. So, to prevent those dangers slowly and sometimes unseemly it has been censored or shielded and altered in particular ways, sometimes for real protection, sometimes for other reasons. Additionally, despite this abundance of information, people are largely in their own section of information, according to their interests and communication partners and habits of everyday life and search engine algorithms. It seems that we will once again be speaking in many different languages – as in different parts of our divided media field, which theoretically was meant to unify humanity and make us proud of our success.*

There should always be critical thinking and experience in the use of a theoretically unlimited amount of information."

(Self-reflection from 26.06.2024.)

Midwives also noted that the level of openness between healthcare providers and service-receivers is lower than before. This is because everything said by professionals is checked on media resources and some kinds of forum. After some unpleasant experiences with younger service receivers and recording, midwives admitted that they tend to think twice before speaking with service-receivers and are not so frank anymore.

Populus: "Younger generation is different. I think we live in an age right now where quite a lot of people do not say what they think, they do not say what they feel. They are afraid to trust, and they think very much about to which person what to tell or not, I think that's it. You do not even know who is recording, or not…maybe."

[16] The Tower of Babel is a biblical narrative found in Chapter 11 of Genesis; It begins with the descendants of Noah speaking one language and wanting to build a tower that would reach the heavens. The word 'Babel' is applicable to the concept of "confusion".

Midwives expressed regret about those cases where a family is not engaging enough in their own child's birth and a midwife constantly must provide motivation and encouragement, but the family do not want to receive it at all.

Salix-alba: "I do not feel very good in situations when I am faced with the fact that I, let's say, participate in the birth of the child more than the family that has arrived here, then I do not feel good."

As confirmation of the many changes within the childbirth process midwives recollected their experience with such simple example as changes through the decades regarding women's birth partners.

Sorbus: "Society is changing, the roles of women and men in society are changing, the attitude towards children is changing, and therefore even if no one could imagine – how will I give birth with my husband? Now you can't imagine how I will give birth without my husband. Birth is no longer such a closed place where men have no place, that it is no more such a separate field for women."

Changes in a woman's ability to withstand the pregnancy and birth process

Some midwives believe that in these times it is inevitable to expect that some woman will lose their innate ability for childbirth. This can be seen from the simple perspective as training for hard physical and boring everyday work, which is performed currently by all kinds of gadgets and robots. This is seen by some midwives as partial pay-off for technical development.

Cydonia: "We don't live naturally anymore. And also, food we are eating…, probably hormonal, because the birth is in the head, there are hormones that should be released, and if they are not released or there is some kind of block... I think mental illness rate is also much higher than before… Childbirth is very physical, the fact that people are not trained for physical things, once they mowed the hay, raked it, gave birth, put the baby aside and went on… Well, a lot of different factors, both the environment and the person, have changed. Evolution, no one goes to the spring to wash clothes or to the river, if we have a washing machine, dishwasher, whatever."

Midwives admitted with regret that they feel that women's innate ability to simply give birth is increasingly rare. They see a link between that and the increase in people's expectations of childbirth and the process of raising a child to be something beautiful without the normal level of difficulty that it usually brings. Midwives noted that they see less parents to be and parents who are ready to sacrifice or put aside their own convenience and comfort, at least for a while, for giving all the best possible for their newborn.

Syringa: "It is probably more difficult for women to accept the fact that a woman should stop thinking about herself, but she should think about the child during childbirth. When a person is on an epidural, on gas, on fentanyl at the same time screams in your ear for 12 hours, not thinking about the fact that she is not breathing for the child…and after birth she says: "Phew [17]," with such grief. I really want to bring her back to reality and tell her that this is just how it starts! You wouldn't tell a child who cries at night like – "I want to sleep, I don't want to feed you, I can't get up." or – "I can't feed you because I'm tired." And it's the hardest thing, that woman doesn't understand it, they think that giving birth and caring for child is cool, easy and so on."

Midwives expressed their lack of comprehension regarding the fact that there is quite a lot of information currently available, incomparably more than even ten years ago, but women are more and more often, for some reason, surprised that pregnancy is not easy, that childbirth is so difficult and painful. Midwives are also surprised by a woman's expectations of beauty in birth, because they see that this it is of course beautiful, magnificent and miraculous, but in your soul and heart. The real physiological act of giving birth is hard work.

Salix-alba: "Well, the patients currently have, I do not know what it is and how it is, but they have such weird thoughts… I do not know in what internet forums they really read all that – that they will come, make sound: bizzzz, and the baby will fall out. They are not really ready for hard work at birth. They just want it to be beautiful."

This shift in women's ability is linked by midwives with two factors; one is the increasing age for women giving birth for the first time, as officially the average age is now 30 years (Official statistics portal of Latvia, 2024) and the second are social trends in the field of information. There is an overabundance of information about how beautiful it is to give birth and how easy it can be if a woman takes the right course or listens to the right podcast.

Thuja: "People nowadays have so strange wishful thinking. They want everything to be ready made for them – they want to touch the phone screen, and the baby will be in their arms... Well, women are weaker, or they are made to feel themselves weaker with information field pressure. Whatever, gestational diabetes definitely depends on what we eat and also the blood pressure and all sorts of other things. Of course, childbearing age also changes for a woman and now it's completely different."

This phenomenon, in turn, causes further problems, according to midwives. When the birth does not take place or happen as planned, people often do not try to receive and listen to the advice of the staff but simply blame on them the fact that everything is bad.

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[17] Sigh of relief and grudge

Padus: "Well, there have been cases when you really tried, you just put all of yourself, you can say all of your energy on one person, with whom you must work for 24 hours. And anyway, the outcome is bad because that's just how people are, they do not hear and do not want to hear or do something by themselves, and so on. At the end they also blame the staff for such outcome, and you can't do anything there."

Corylos: "The women's inability to withstand and work for childbearing or inability of the accompanying person is a problem."

Midwives also point to a diminished human capacity to wait. In a simple example involving birth induction, midwives often encounter the fact that women and their birth partners are confused about why the baby has not been born 24 hours after entering the ward.

Malus: "Well, they think that it will be that – I came in and baby will be born today, and then sometimes there is a 3-day induction. And then on the second day she says: "I'm tired of everything and do something to get him out!"

All the midwives interviewed who work in hospital settings noted that there is a general decrease in women's ability to tolerate hard work during childbirth, with some exceptions. There is a changing pattern where previously it was the exception for women to be unable to withstand the pain of childbirth; these days, it is the other way round. It is now the exception for someone to give birth physiologically and without complaining about how unbearably difficult it is.

Thuja: "I sometimes envy those home birth midwives, because, for them, those women are basically ready. No, it's true that they also scream: "I can't!" It happens everywhere, but in hospital we have to motivate them constantly, motivate to give birth to their own child! In the end, you don't know what you can do more for motivation, because she is thinking only about how tired she is and she doesn't even care: "Do what you want, just pull it out!" The main thing is that they must be ready for hard work."

From my own reflective notes about a woman's ability to withstand pregnancy:

"There are authors who noted that for a positive and healthy birth experience a woman should, firstly, make spiritual contact with herself (Ayers-Gould, 2000). And others reminded that we however are creatures of universe (Miller, 2019).

And then I think there are contemporary human being with all the gadgets and technological possibilities and endless, …endless field of a constantly-regenerating field of information. This amount of information and background noise could simply create distraction for women even in getting her possible connection with herself spiritually. And how can even it could be achieved in birth, if it was not practiced ever before in life, if from

early childhood life was constantly organised, made entertaining for you, with no possibilities just to be with oneself in nature, with no gadgets or organised activities by others?

It goes deep in childhood. As a researcher in Sweden described, the beneficial aspects of the necessity of being outside in free play, with no instructions for what should be done by adults, allowing children to understand what is happening around them and within them and what they really want to do (Lund Fasting & Høyem, 2024).

And again, it is nothing new, in 1930s, almost hundred years ago writer Agatha Christie had similar thoughts whilst accompanying archaeological excavations in Syria and Iraq:

"The air is wonderfully sweet. It is one of those moments when it is good to be alive. The foremen are grinning happily; small children driving cows come and gaze shyly. They are dressed in incredible rags; their teeth gleam white as they smile. I think to myself how happy they look, and what a pleasant life it is; like the fairy stories of old, wandering about over the hills herding cattle, sometimes sitting and singing. At this time of day, the so-called fortunate children in European lands are setting out for the crowded classroom, sitting on benches or at the desks, toiling over letters of the alphabet, listening to a teacher, writing with cramped fingers. I wonder to myself whether, one day a hundred years or so ahead, we shall say in shocked accents: "In those days they made poor little children go to school, sitting inside buildings at desks for hours a day! Isn't it terrible to think of! Little children!" (Christie & Hawkes, 1946, 91).

And here we are, after 100 years, we still force children to be inside at the desks for so many hours. Considering these long hours inside and gadgets with an abundance of a constantly-regenerating field of information, all this starting from early childhood, it just seems logical that it is harder and harder to hear yourself and make this spiritual connection with yourself, so essential for women's ability to withstand giving birth.

(Self-reflection from 14.03.2024.)

4.2.2 Medicalisation of physiological processes in perinatal care

Three main branches of this theme emerged; the struggle between midwives' beliefs versus current guidelines, the wish to broadcast midwives' voice more in media and the varying levels of awareness and attitudes of midwives towards these current guidelines.

Midwives openly stated their disbelief in the latest birth induction guidelines. The answers to questions on this topic did not take even a second of thought.

Quercus: "I don't believe in the latest guidelines."

Midwives explained their quick negative answers as based on what they see in their everyday professional life. They do not understand why there has been a sudden increase in induced births and cannot see any reason for it. From a midwife's point of view, induction makes women feel unable to trust their innate ability and takes away the empowerment of the birth process. As midwives support women throughout the birthing process, they can see how much harder it is compared to births that started naturally.

Picea: "..., but we are having a hard time. I can actually see that we are having a very difficult time when we are following the guidelines. And women are having so hard birth experience."

Midwives expressed their concerns and outrage about the latest birth induction guidelines and disbelief in their truthfulness. They reflected that, even two years ago, there were a lot of women giving birth after the 40th gestational week, and they do not recall there being a problem with that. They see these new guidelines as simply stemming from hospitals competing to increase their birth numbers.

Picea: "I don't understand, where's the problem! Even two years ago, we had lots of women in their week 40 and even 41, and everything was fine. They've gone totally mad with those inductions – everybody should be induced, even those who come in just to check baby's heartbeat."

Midwives outlined their outrage at the latest birth induction guideline with sadness and great emotion. They admitted frankly that they saw no point in them, especially the point where induction could be performed from only the 39th gestational week if women wish it to be done, with no medical reason for it. There was verbal confusion and denial regarding these aggressive steps not only in birth induction, but also in stimulation measures.

Cerasus: "*This is a very difficult question, because sometimes it seems that the latest guidelines, where birth can be induced from 39 weeks simply because of the woman's will! I am still in shock – to say nothing, because it is too much! Or, for example, after 2 hours after the amniotic fluid has broken, birth process has been induced, it's too much in my opinion. Every year childbirth is becoming more and more of a medical process. Of course, also from the other perspective, how healthy women are now and how much a woman can lead her own birth and give birth by herself is a very debatable question, but in general I believe that there are too many interventions in the birth process. These strict guidelines that are in place now, those time limits that you can't wait any longer."*

One of the reasons cited by midwives for this is the desire of outpatient specialists to remove responsibility for the pregnant woman from themselves as soon as possible and to send her away to hospital for induction. Midwives stressed the importance of individualised care where every step should be analysed before taking action. They commented on those induction

rates as totally unacceptable and said that care of pregnant women is undertaken without any consideration of individual approach and responsibility.

Pyrus: "Well, I hate new induction guidelines, I'll be honest, I just can't stand it! I'm not the only one, my colleagues and I have talked about it. I would say that there is no such thing as individual approach in reality. The use of guidelines must be evaluated individually, looking at all the parameters, but in general it is simply avoiding the responsibility. For example, the specialists want to remove the responsibility from themselves, roughly – "For her 39 weeks, she has IVF[18], that's it!", but maybe she's fine, has a normal pregnancy despite the IVF, maybe she doesn't have any chronic diseases. Why should she have an induction at 39 weeks?"

Midwives expressed concerns about what these induction-induced hormonal surges do to the woman not only during birth, but also in the postpartum period. This period after birth, with its emotional and psychological challenges, was described as difficult in itself. Midwives expressed concern that the surge of these extra synthetic hormones could make this period even more psychologically difficult, comparing it to climbing Everest and then rolling down from it.

Cydonia: "Well, this is very, very crazy! I think all midwives are very worried about those induction rates, because it is so difficult primarily due to the woman's pain threshold. With induction she goes to abnormal hormonal level heights. And I mean also after childbirth, what we're talking about with these postpartum depressions, it's all about the same. If you hormonally climb up to Everest, then after birth, of course, you will fall down from that same Everest!"

The common position was that obstetrics was moving more and more away from physiology towards medical manipulation and complications. Since they change more and more often and there is no discernible reason for them, midwives lose faith in them altogether.

Cydonia: "Well, I mean, we're moving more and more away from natural childbirth. We are moving more and more into the field of doctors, where doctors are in charge, so that intimacy and the role of midwives are disappearing."

Quercus: "I don't believe in the latest guidelines. Well, actually, for us, the guidelines change too often."

Midwives admitted that, in theory, guidelines should be a tool for help and protection for those who work in perinatal healthcare and service receivers, but in fact midwives described them as a hinderance and obstacles to provision of individualised care for women.

Thuja: "The worst thing is that, how can it be said…, that you are limited in some way, even if you know when it would be better to do something, but you can't really do it because you have guideline frames, in which you are placed."

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[18] IVF – in vitro fertilisation

Corylos: "Well, I think, first of all, the current guidelines are changing too much. And does everything really have such a scientific basis? Yes, I think this is taken out of context. And I think I've already observed that we tend to adopt some kind of guidelines, do it for a while, and then put it back to the way it was, the way it was before."

Midwives describe their latest experience with growing induction rates as disturbing and horrifying, because they see them as representing and stemming from the race for growing birth numbers between hospitals. They don't see any individualisation of care in it, just doctors grabbing more patients for their hospital.

*Picea: "The ones that bother me the most are the ones about those abnormal suggestions for induction. I don't even think it matters which woman comes to the ***, they pull her into that "wheel of inductions" and say: "Maybe you should have an induction?" Even if she doesn't have, let's say, very serious reasons."*

Midwives describe their disbelief in the latest induction guidelines by seeing no credible basis for them. According to them, two or three studies, moreover, in another country, are not a basis for manipulating the entire approach to maternity care.

Thuja: "We are talking about the guidelines here, I think there is something in common and I don't understand the latest trends, but where has our old traditional obstetrics gone? Let's say waiting for deadlines or the principles of calculating the due date of childbirth, the new ones work only after ultrasonography, forget your period, forget your thoughts, forget ovulation. I don't understand where it has gone, and it drives me crazy!"

From my own reflection about the medicalisation of childbirth and midwives' expressed disbelief towards it:

"This was already discussed 20 years ago by researchers who tried to find out where this needs to control the birth and movement of natural birth against it in Britain came from (Moscucci, 2003)*. They noted that the concept of natural childbirth is hard to define as there are two big concepts of health and illness, which goes together with societal anxiety regarding hereditary diseases, and this anxiety is strengthened still further by the current declining birth rates and people needing to have a healthy next generation. As I see it, almost every family wants a genetic screening to be done; there are only few who don't. So, with a higher average age of first-time mothers and all kind of new possibilities in diagnostics, even before pregnancy, the medicalisation of childbearing is inevitable."*

(Self-reflection from 20.11.2023.)

The expressed wish by midwives for more broadcasting in media of their attitude towards the medicalisation of childbirth

Midwives expressed the view that there is a need to speak more openly and loudly about childbirth in the media. This would give people more opportunity to make their own considered decisions about the childbirth process and which medical interventions they do or do not consent to.

Larix-mill: "In society as a whole, there should be more discussion about the fact that everyone has their own responsibility, takes responsibility and changes what they can."

Some midwives expressed the opinion that there should be more information for woman about how important it is to prepare themselves for the hard work involved in giving birth. They should be told that it requires more than listening the specific courses and that it should involve more practical work by women themselves and include physical activity.

Sorbus: "I would like to tell them that pregnancy is the time when you have to work hard on yourself, to be ready for that process, because when the birth comes, there will be no more time for that."

Midwives also expressed the need to express themselves loudly in public so they could be seen more as independent professionals with whom families to be can consult even before entering the childbirth process and get as much possible information about the physiological side of it.

Ulmus: "Midwives have some, but the prestige must be raised, because many, many still don't understand what midwives do at their work, why they do it and so on, about this profession in general."

From my own reflective notes about need of midwives' voices to be broadcast more:

"Overall, there is so much information about what is normal, what is pathological. There is not so much or full information about what or how it is individually for every woman and midwives' views relating to that. According to authors from UK (Darra and Murphy, 2016) *the current models were described as dichotomous, separating normal from abnormal. This is far from everyday practice in perinatal care, where every birth is as unique as every human being.*

The need of women for knowledgeable midwives was also noted. This is so they can cope with their own individual childbearing process, so rarely described within this dichotomous model of 'normal' or 'abnormal'. This goes together with what midwives noted in this research, i.e. that there should be more of practicing midwives' voices in media.

Current dichotomous models and theories relating to birth and midwifery, separating the normal from the abnormal and non-intervention from intervention, don't fully explain the perspectives of women or their midwives. Women want to cope with labour and birth with the help of knowledgeable midwives.

In all this debate about what is normal and what is not, the uniqueness of each human and birth somehow is slipping away; it is not possible to put in on just two sides. This is similar, as mentioned in the introduction, to what Max Weber described a hundred years ago as the 'iron cage' and the file system (Gubrium et al., 2016, 5–7; Maley, 2004).

Birth cannot be dichotomous; it is individual and that is why a knowledgeable midwife is needed.

Even our own Latvian language explains this, as the old word for birth was 'radības' (in Latvian), derived from the verb 'radīt'. Translated into English, it means 'to create'. A creative process cannot simply be 'normal' or 'abnormal'; it is an interesting rural road with ups and downs, mud and dry and slippery or wet and flat gravel, crosswinds and a wind that blows at one's back and carries you forward easily, visibility may be clear, but fog, rain showers or an opaque blizzard are also possible. When on the rural road, pleasant or disturbing encounters are also possible when meeting a forest dweller.

(Self-reflection from 05.06.2024.)

Varying awareness of and attitudes towards current guidelines

Some midwives expressed their opinion that the guidelines are merely recommendations and should remain so, because they are not law. The other question is whether the perinatal healthcare specialists want to take responsibility and answer questions the way they chose one or another way. The rather dubious aspect of the guidelines is that they create an opportunity to avoid responsibility by claiming that actions were in accordance with the guidelines.

Malus: "Well, yes, and the fact that the guidelines are just recommendations, but often this is not what I see on a daily basis. And I think that it is not only me, if that recommending aspect disappears and that there is just a mandatory one. For example, now the analysis shows that there is a risk of developing some complications, so today you have to give birth, but nothing has developed yet. Everything is still good. And imagine, if we remain such servants of the letter, it is probably easier to operate on everyone in 38 weeks and 6 days. The work is planned, and everything is very good. Well, you understand my kind of ironic sarcasm, but it is very difficult to work with the current birth induction guidelines."

There was also varying awareness among midwives about current guidelines as such. There were also midwives who honestly admitted that they tended to work as they had been

taught during the process of becoming a midwife or according to the familiar order of their workplace.

Alnus: "Guidelines, – I don't remember when we touched it specifically, – last time at school, maybe something has changed?"

Midwives admitted that use of guidelines depended not only on one or other birth unit, but also on the team working in the same shift. It is possible for colleagues from the same department to interpret guidelines differently.

Pyrus: "Well, it's just some mess, I don't know – mess and horrors! And also, everyone interprets in their own way. We have also been talking to other hospitals."

Cydonia: "There are different situations, there are different colleagues. Then again there is a different relationship with each doctor, each doctor has his own handwriting, just like a midwife and, therefore, also there is always different kind of guideline interpretation."

Another issue regarding the guidelines is that not all the personnel is aware of them or practices them, believing more in their professional judgement and experience. This is even true about those recommendations from the WHO in 2018. Unlike in previous years, there is no lack of information, as LMA and GYNASOC have created a wealth of information through lifelong learning courses, seminars and conferences, most of which are online. These concerns were mostly expressed in situations where a strong hierarchy at work meant that the presence of older obstetricians and midwives reduced the ability of younger midwives to implement the latest WHO guidelines in practice.

Cydonia: "Sometimes a lot of unnecessary vaginal massage in birth, but we were always taught – "Keep your hands off the vagina or perineum, touch it only when it's necessary!" And Kristeller is still being used by older doctors. And here is the hierarchy, well, you, as a midwife, what can you say to doctor who has been working for 40 years? How can you protect the woman?! This is a nightmare!... Still, what's going on sometimes…"

Midwives describe night shifts as sometimes the only period in the shift when they can provide women-centred care and perform their professional duties in accordance with latest WHO guidelines and their own professional experience, belief and conscience. As those colleagues who want to intervene and act usually want to sleep at nighttime.

Aronia: "Nights are the times when I can normally and calmly let that child sleep on mother's belly in 'skin-to skin-contact', then no one tells me to weigh and measure him faster, as if he will weigh more or less in 15 minutes, at nighttime everything can be done in such,… such calmness."

Midwives talked about their colleagues' disbelief in the guidelines published in the last decade. Even those that are no longer particularly new, like skin-to-skin contact and the 'golden

hour' and so on. They expressed confusion about the fact that information is shared repeatedly at courses, conferences and seminars, where everyone listens to and sees the same thing, yet some colleagues still do not implement it in practice.

Quercus: "Those lifelong learning courses… they come, they sit down, they listen, but they continue to do the same thing! Literally, doing the same – I don't know how to fight it."

4.3 III Theme: Concept of communication

In terms of the duration of the dialogues and the amount of text, this was the largest theme and one in which main three subthemes were highlighted: the factors influencing communication, inter-generational communication and the uplifting effect of the expression "Thank You!" (see Annex 3). The two last themes were highlighted separately, because those themes wind their way through the midwives' narratives of all the other themes during interviews.

4.3.1 Factors influencing communication

This theme had eight subthemes:

- the aspect of individuality in communication;
- the size of the team at work;
- first impressions;
- barriers to efficient communication at work;
- non-verbal communication;
- the ability to distinguish between subjective and constructive criticism;
- hierarchy at work;
- the impact of workplace layout and team size on communication issues.

Aspect of individuality in communication

Reflecting on influencing factors of communication at work and in midwifery in general, midwives openly stated that communication starts with your own perception of the world. You cannot expect acceptance or positive attitude from others if you are criticising yourself all the time.

Populus: "If you think negatively about people in general, it means that you are already mirroring yourself. You don't think anything good of yourself either, well it's true, then it goes hand in hand."

Some midwives openly criticised midwives who were their own colleagues by recalling the old saying: "You can see the splinter in another's person eye, but you do not see the log in your own." They noted that midwives probably need to look at themselves more deeply.

Populus: "What amazes or surprises me is that, that midwives, well in my work, if the collective thought, they are very monolithic. And only a few individual people can somehow not represent it. This thought is so monolithic: everything is bad or the doctors, well, …everything is bad around and is bad in general, but only we midwives, – we are fine."

Midwives expressed the view that there is a significant issue of simple human nature: it matters who you work with on a shift, regardless of what professional they are. What matters is who they truly are as a person.

Corylos: "It depends on the teammates, because there are those with whom you get along half-heartedly and there are those with whom you would not want to meet at all. Not only in the birthing room, but also in a dark corner of the street."

It could be described figuratively at times as a drop of tar in a barrel of honey. A whole team could be united and work easily together, but if there is just one colleague with a negative attitude it can tear apart every feeling of mutual support and understanding between colleagues at work.

Alnus: *"An important factor is how I am with my colleagues, because it is one of the factors why I, for example, don't want to go to work on holidays… because there is one specific colleague, unfortunately… who tyrannises absolutely everyone, so I think this is a very important fact."*

Midwives pointed out that a cohesive team at work with understanding and supportive colleagues is key to satisfaction with their current job and at their specific workplace. The supporting shoulder of a colleague and the help colleagues give each other with such tasks as filling in the endless documentation if someone had not managed to do it in the previous shift, is sincerely appreciated. It is also noted as an important factor in ensuring work-life balance.

Cerasus: *"Here, is a very cool team for me, that when I'm driving from work and going home, I don't have to think about what I didn't write down there or where I made a mistake, what notebook on the refrigerator of medicine I didn't sign, did I not sign for some ampoule. I understand here that we have such a good collective. Since the midwife is alone and there is a lot of work and you have all the stages in birth and postpartum and sometimes even you must help with something in gynaecology, you may actually miss some paperwork and not remember about some notebook in the refrigerator or in safe. It will be the last thing you think about! That's why, if someone of us did not finish anything, next midwife just come, take it and do it... So, with this workplace it's much better for me to let go of my thoughts and clear my head between working days."*

Midwives elaborated on the issue of team members at work who have different points of view in the same situation during care for a birthing woman. A midwife can put a lot of

energy and motivation into enabling a woman to take one or other position or adopt a certain breathing technique, only for a gynaecologist to suddenly open the door and hastily give completely different directions without evaluating the situation and what had been done before.

Cupressus: "It very much depends on exactly the particular team in that shift. The most classic example of postures and breathing. A midwife can put in a lot of work, but if the door suddenly opens and a doctor walks in, because he is a doctor and he knows everything better, he can in one swoop turn her around. Even though he has not seen that situation before and has not assessed that this is exactly what is currently working, including the woman's wishes into account."

Midwives expressed different approaches to communication itself. There were midwives who pointed out that the main thing is not colleagues, but a midwife's own ability to do everything possible to provide a woman with positive healthcare experience, no matter what.

Alnus: "I believe that most women should have a positive birth experience. Of course, all should be pleasant experiences, but there are different experiences. It should be a pleasant experience in terms of attitude."

There were midwives who expressed mostly concerns towards communication issues with some colleagues, especially doctors. They see the big problem as hierarchy at work and it's harming influence in all teamwork.

Salix-alba: "There are doctors who respect midwifes and there are doctors who will try to level you with the ground."

Midwives expressed the opinion that communication demands a never-ending individual approach and that different colleagues and a different woman will always surprise you. This is because every human being has his or her own world view. Some midwives proposed constant feedback in communication as a tool for dealing with it.

Quercus: "Sometimes it seems – do you really need to work like at kindergarten with adults? But sometimes you do! And for me personally, it's difficult for me, no matter how to break it all and simplify, how do you say or express the idea of what needs to be done, but do not put a, b, c, d as points … Yes, but it's about the fact that, okay, we all think that an apple is red, yellow, green or with green bumps or something. And yes, one imagines one thing, but ideologically there is another. Well, yes, it needs to be talked about more, feedback is needed."

Size of the team at work

Midwives expressed their favour towards working in smaller birth units. They expressed the opinion that there are more possibilities to provide woman-centred care, and they are friendlier towards the care process itself. Because there is one midwife, the same professional

who admits women takes care of them during birth and then in the postpartum period. The woman can feel safer because the same person is always there and there are fewer people involved in general, and the same questions are not asked repeatedly because it is the same midwife who admits and cares for them. This in turn additionally facilitates the entire birthing process, because the woman is not disturbed unnecessarily, and she gets to know the midwife from the very beginning. Women also know where exactly the midwife is and the midwife hears perfectly how she breathes or talks with her partner, so she knows how the birth process is going and does not disturb women unnecessarily.

Alnus: "*Of course, professionalism, the art of working with different women, how to read them: when a woman wants to be alone and when you can really feel when she grew up in a big family, you go somewhere and she shouts after you: "Midwife, come back, I'm afraid to be left alone!" And in small departments, the charm lies in the fact that I meet women from the beginning, and I then accompany her all that time. And I can get to know her and understand what her desires are."*

Midwives who had experience in different sizes and types of teams at work, even expressed the opinion that it is the best model for midwifery, to work with other colleagues in small teams of 3 to 4 perinatal healthcare professionals. This could be because they know each other well and understand each other without having to say much at all.

Thuja: "Any midwifery is hidden in a cohesive small team. It is more than clear that mutual trusting joint work must be achieved within the framework of 3–4 colleagues in one shift."

First impressions

Midwives pointed out that in this profession first impressions are sometimes crucial, because for good health outcomes midwives need to be trusted by care receivers. As birth sometimes progresses very quickly, even in admission, midwives should be able to gain trust instantly, from the moment they meet the woman with her partner.

Alnus: "*I wouldn't be able to come to work with, let's say, dirty hair. I think it says a lot right away that first few seconds about how professional he is, how clean his suit is ironed and his hair and everything else."*

Midwives also noted that this is not so easy to achieve. As everybody knows children tend to come when they want to and there are calm shifts and there are those shifts where it is scarcely possible to note the data of the woman and the child, as one is born after the other. The woman who is admitted next does not then see a midwife in her best, in ironed scrubs and with smoothly-combed hair.

Percica: "We have sometimes so hard shifts. You are exhausted and with some amniotic fluid on you or even some blood stains, what you didn't saw because of the workload, your hair is a mess, you are sweating… And then there comes another woman in admission… I sometimes think, how horrible and funny in black humorous way is that in your child's birthday someone like that is welcoming you and you should also trust that person, ha!"

Barriers to efficient communication at work

Six main barriers to efficient communication at work were highlighted when analysing interview dialogues with midwives: mobbing, unhealthy and exaggerated hierarchy, backbiting, noise and rush, foreign language skills and unresponsiveness of doctors on duty and the lack of communication between colleagues in the same healthcare facility as among different sectors of them.

Mobbing and unhealthy and exaggerated hierarchy were described as serious issues not only for professional communication, but issues that also caused midwives to consider whether it was even worth going to such a place of work at all. In some interviews it was described as like communication in prison; where there are prison guards and prisoners of higher and lower rank.

Cydonia: "Sometimes I feel like we live in some kind of prison, because of the mobbing and splitting are so apparent; there are doctors against midwives, then there are the old ones against the young ones, Latvians against Russians. Yes, this is how it is."

Cerasus: "If before I had such a position that I would fight for midwifery, now I don't have it anymore, now I don't have the strength anymore. For me, that character was gnawed and eaten by the xxx hospital very, very, …so very much. And the motivation to do more disappeared."

Midwives acknowledge that backbiting is a serious barrier to effective communication, because in some birth units it is normal everyday thing. It is sometimes even done in such a loud manner that even service receivers hear everything from their rooms. Some midwives expressed wonder at how it is even currently possible, as not only colleagues, but also service receivers do not accept such behaviour.

Padus: "I want to work in a pleasant environment. And there are often such shifts that you're just like against the wall all the time, and you don't feel good, and you feel maybe sometimes even humiliated. We have quite a large epidemic of backbiting at work. You sit and think, where do you come in – in a chicken coop? There is no respect for patients or colleagues, it is disturbing."

Some midwives reflected that not only the fact of backbiting and noise is an issue, but such an attitude towards other human beings is disturbing. Because midwives should be

professionals who accept any kind of service receiver, no matter how unusual she or her partner is. Some also thought that it could possibly be an unconscious or conscious reaction to protect oneself, as midwife from too much emotional load.

Populus: "Well, noise, I don't like noise, I don't like noise, noise around... Yes, I don't like the sarcasm and cynicism I see in the workplace. And I can explain it to myself and justify that it is because sarcasm and cynicism, it helps people and remove the huge tension they feel. Whether they consciously understand it or not, I don't know. It's a very good protective reaction, they laugh at everything, like being a little against everything, and even make fun of it sometimes, and it bothers me a lot."

Lack of foreign language skills (English or Russian) were also admitted by midwives as a serious barrier to efficient communication with service receivers. This is because in pregnancy, birth, or postpartum care there is a great deal of explanatory and conversational work to be done, and a lack of mutually comprehensible language is a great barrier.

Ribes vulgares: "It helps if the woman speaks Latvian or English. Not so good if they speak only Ukrainian or Russian, I can't do anything there. And then I must try to communicate somehow ..."

Unresponsiveness of doctors on duty was another barrier noted by midwives. Midwives talked about how important it is to feel support from the doctors in unclear cases, when this boarder between physiology and pathology is not so clear. In these cases, the logical first step would be to call the doctor on duty, but there are some who will not give a consultation but start to divide patients and try to evade responsibility, even if in this shift they are in charge.

Salix-alba: "I actually called the chief to explain the situation, because to whom else to call, if not a guru, if not a professor. This time, that day, she once again strictly tells me: "You shouldn't call me, she is not my patient!" And how is that even possible? At work, when you are on duty!"

Midwives also highlighted the need to provide more feedback between colleagues and patients. They recognise that each person has a different point of view and even how we see the simplest things from different perspectives to other people. To be able to provide perinatal healthcare in a safe and respectful way for everybody, there should be constant feedback between professionals. For example, currently there are episodes of miscommunication between different perinatal healthcare professionals; one is working in outpatient clinics and one in a hospital setting.

Malus: "And also communication among different specialists. We sometimes stand against each other, where there is a patient in the middle, a pregnant woman. And she receives one kind of information from one-by-one specialist in outpatient clinic, well, that birth should

be induced, because... and often on the opposite side in hospital they say – no! You can wait because... and then it doesn't enhance mutual trust."

Midwives also noted that newly-implemented, obligatory, lifelong learning courses in communication for perinatal specialists should take place in real workplaces, in those birthing rooms where they work and with those colleagues with whom you really work, not in some other place with colleagues from other units. They admitted that they did not see the point of sitting and listening to theory about efficient communication, as, in midwives' opinion, it should be simpler and done via short situation simulations in the actual workplace.

Malus: *"And you came and what they said there … and it doesn't make sense, we can't implement it here, but when it happens in our real workplace, then: "Oh, well, we can do it that way too, we need to remodel planning of furniture, maybe put some more comfortable tables or do something else, and it will work even cooler", but sometimes it happens in a foreign environment and maybe at some point even in a perfectly organised environment. Team communication training should take place in real workplaces with real everyday colleagues."*

Non-verbal communication

Midwives noted that the art of reading body language comes with the experience. After a while in this profession, it is possible to start to read people. They also noted that only after acquiring this skill is it possible to start communicating with people properly. This art of reading body language was described as essential in midwifery practice.

Betula: "After a few years in the profession, you will already begin to understand. You will already start to recognise that mimicry and so on, and how a person stands, how he folds his arms, and the rest. And then, maybe you will somehow manage to cooperate with him."

Going into more depth on this theme, midwives explained that for this skill to be able to read non-verbal communication and to be able to answer in that same non-verbal way, a midwife must have a good emotional control. A service receiver must not be able to read your non-verbal signals of, for example, disbelief at a good outcome or your irritability. A midwife should have a good emotional control not only in verbal language, but also in body language.

Populus: "And what keeps me in it is that I have very good emotional control. I know that. I can control my emotions very well… Well, we should probably return to the classic value of "In the beginning there was the word.", but body language is so very important for a midwife."

Included in the concept of non-verbal communication were also the required speed and sound level for midwifery activities. Midwives remembered how sometimes it took a lot of effort to explain and teach young colleagues about such small things as how to close the doors.

As a midwife, who works in birth units or other healthcare establishments, one should always remember how sensitive to noise and a midwife's body language a woman is during the perinatal period. No matter in what urgent or stressful situation a midwife is now working, she should always control her body language and physical actions.

Corylos: "I was in birth with a student, and the student walked out of the delivery room 3 times, slamming the doors loudly. The other midwife was sitting behind the door and heard it. Already the first time I really took a breath, and I thought it was just me, probably my problem. And at the same time, my colleague told me that she had noticed the same thing. She scolded the student, telling her: 'A person gives birth there. Keep it in mind!'"

Especially essential is the ability to read body language in those emotionally grave situations, like in stillbirth or situations were women expresses the wish to give away child right after birth. Midwife should be able to read without words when to come closer, when to ask and when just to be near and silently wait, when, without words, in total silence, to understand that parents are ready to give away their stillborn child into a midwife's hands.

Juniperus: "She kept her hands across the child and didn't want to give the child away. I saw it, but with her mouth she said: "I'm giving the child away" ... after a while, at the end she gave me the child."

Ability to distinguish between subjective and constructive criticism

Midwives openly talked about the necessity in this profession to be able to listen to every kind of unpleasant comment about yourself and to be able to distinguish them from what really happened, what were the real health results for the woman and child. Midwives, as they see it, should be able to know and feel for herself what is right and what is wrong. Other colleagues may comment in an unprofessional or even offensive manner at times. They should maintain their inner core, so as not to become like those very people who have treated them like that.

Picea: "I don't really take offense. I have told myself that whatever happens or whatever somebody has been saying, the main thing is that everything is fine with that child… You must learn to live with every kind of criticism and emotional outbursts, because otherwise you will get to the mad house, or you will start to scold yourself and you will scold others also."

Midwives also noted that this does not mean they do not want to hear constructive criticism. Their objections are to rudeness, cruelty, unprofessional comments and disparaging attitudes, but not to helpful criticism as such. Midwives admitted that honesty is crucial in midwifery practice but should be expressed in a polite and kind way.

Quercus: "Well, for me, value is honesty, value in general. It is very important for me to have honest, but kind people around me. It is definitely easier to communicate with them."

Hierarchy at work

Midwives admitted that we talk a lot about horizontal hierarchy in the workplace, and there are even obligatory lifelong courses on the topic for everyone working in perinatal care, but the reality is still opposite, it is still true with hierarchy still very much vertical from doctors to midwives.

Syringa: "I want those midwives to cooperate more with the doctor, we had those communication courses that I really liked, when doctors, midwives talk together on the same level, in the same situation and each from their own point of view. We are also smart people, you know. We also read, we also study, and we probably spend more time studying than I don't know, some doctor."

Midwives reflected that they observed great difficulty in terms of contact and hierarchy during shift work in hospitals. Midwives said that they still sometimes felt powerless because it is not accepted in these institutions to oppose the doctor. One must follow their instructions, regardless of their level of experience.

Malus: "And what can you do! He has already spoken with women without you, you see that this is not the best course of action, but he is a doctor, no matter how "green" or experienced."

Midwives admitted that within this vertical hierarchy from doctor to midwife that still exists there is not much, as they see it, that they could improve to minimise the side effects of this hierarchy in communication. Midwives propose, as one solution, documentation about what possibilities there might be to protect themselves. They also mentioned the idea of '*growing a thicker skin'*. Midwives do not believe that doctors will change, but see more opportunities in changing their own attitude towards both the doctors and themselves.

Pyrus: "You don't call the doctor sometimes, when you even need to, fearing the reaction, and accusations that you can't cope on your own, but it's time to grow a thicker skin, they will not change. We both are working for the woman. I don't know how to draw those boundaries, it's quite difficult. The legal side of it, maybe … we also must consider the fact that you answer for it afterwards. Maybe then that also puts a "stop sign", so whoever is on the other end of the unit, we call him if necessary. We call five times, if necessary."

As a way of dealing with this vertical hierarchy midwives report the practice of ignoring it. They tend to focus on the woman and child rather than comments made by doctors about their work or practical techniques they had used. Inside themselves, in their hearts, midwives know what is right and try to follow that inner belief that they are capable and independent healthcare specialists.

Populus: "Our doctors and management tend to have such an ailment, everyone will always want to comment like superiors about obstetrics and your actions, but: "You stand, like you have bananas in your ears, you don't hear anything." And this has helped me a lot now and then, somehow, as they say: "The dogs are barking, but the caravan is moving on," something like that."

From self-reflection notes about communication barriers at work:

"It is such a dangerous and common thing in the Latvian nation historically, which is deeply embedded in the memory of our genes. In order to survive after the regime, change by the new conquerors (Swedes, Poles, Germans, Russians, etc.), we keep our mouths shut and would rather not say out loud what we think, so that we have a better chance to survive successfully. There is a behavioural pattern present today: don't stand out and don't loudly protect someone or ourselves. ***This helps to survive, but it does not help create any changes in communication.***

Likewise in literature, when talking about physical and verbal abuse in the maternity care system, there is honest reflection that even trying to resolve such a complex issue as the changing of behaviour patterns can lead to a sense of helplessness, especially when many have tried before with no successes (Downe et al., 2023). *Authors conclude, that in order to effect positive change, sustainable changes in attitudes and beliefs need to occur that will then promote permanent changes in behaviour. This must, however, occur at all levels of the socio-ecological system; front-line staff, including also management who sets the tone for organisational tone and leaders of local communities.* ***In this article was a very important and true note, that there is no use in completing formal intervention programme/-s for behavioural and communication change,[19] if people are still "othering" and don't see each other as equal human beings on this planet.***

We cannot expect appropriate communication with every woman and family if there are still problems with communication among medical professionals, their management and leaders of communities."

(Self-reflection from 01.04.2024.)

Midwives compare the styles of communication between midwives and doctors as follows: midwives are more patient and less rushed; doctors tend to try to break in and resolve quickly what they can.

[19] In Latvia all medical professionals working in perinatal health care should once in five years complete life-longing learning course in communication.

Cydonia: "I think, midwives go more, try to do some such things with the postures also during the pushing phase. Doctors are simpler, they need it to be resolved as quickly as possible, time is running out: "Let's give birth quickly, come on, come on!"

Midwives admitted that they are not always able to object to doctors. Even if they have a lot of experience and a doctor does not, they do not feel that they can really say what they think, as they feel they should follow the rules of deontology.

Thuja: "What really pisses me off is the young colleagues from the doctor's side who take one such blunt thing in their head – neither right nor left – and you are like in the middle, between women's needs and wishes and this young doctor's opinion. If I would be on the street, then I would punch him in the face for that. If I'm in a department, they're in the highest-ranking category above me."

Significance of workplace layout and size of the team on communication issues

Midwives reflected on the issue of the number of people in one maternity ward in terms of healthcare personnel. They felt that for birth-care units with many midwives on one shift and more than 3 to 4 birthing women in one unit it is too much to practice effective communication. They explained that the birth process on its own is a stressful situation, so it is not compatible with many personnel.

Populus: "I sometimes think, is this way of thinking, behaving, perceiving also present in small hospitals where there is a smaller collective? However, if I think about it, maybe it's because here, in our workplace, the masses are terrible, so many people and there, ...well, somehow the general attitude towards each other is horrible. We are just too many people here in one room."

Midwives also elaborated on the issue of the size of the team from the point of view that when the manager of the unit has smaller teams, it is more feasible to have a conversation with anybody who needs it. There is much more opportunity to change or improve things because in smaller teams people can be reached more easily. They also do not get tired of each other. Because a midwife's profession is one which demands providing intimacy, midwives acknowledge that they like to work alone or in pairs and do not like to be with many people at work.

Cydonia: "You can't just work in a monolithic herd. Such a relationship is forming with every individual doctor, individual midwife, no matter who. And with each person you have, well, with each one, for example, a doctor or a midwife, they will react differently with each other."

Considering the amount of stressful situations at work, midwives stressed the need for a safe space at work, where it is possible to go and have some reflection or relaxation after stressful situations or periods of huge workload. It should provide peace and quiet.

Thuja: "There is no comfort zone, maybe even in terms of the space, where you could do what you need to do calmly, instead everything is tossing and turning. Well, it's like they (management) say: that's this department, that's how it is, ...you won't be able to change anything there."

Overall, midwives admitted that it could be hard work, to lead a group of women. This and the issue of how stressful and emotionally demanding the profession inherently is, they see as one of main reasons why midwives should not work in large units.

Pyrus: "In small departments, it is easier to sort out the issue of communication. It is much easier to achieve their improvement, because it is really possible for the manager to pay attention to everyone. Not as in such a huge group of women, which you have to try to gather, that collective of women."

Midwives see the organisation of lifelong obligatory courses, happening only in their workplace with real co-workers, in the same rooms where the work has been done, as a possible way to improve the situation significantly. Currently these courses are held elsewhere, in idealised or artificial environments rather than in real, everyday work rooms. Midwives admitted that it is not easy to put the tips learned on communication courses into practice at work and said that this would take a lot of work from management.

Pyrus: "Neonatal resuscitation, teamwork as a minimum should be organised courses at least once a year. And they must be organised at the workplace, where you work in the same premises and not somewhere else. Every department needs those workshops on the spot, with those persons you actually work with on a daily basis. Then you will be able to see how much we do in reality. This is the ideal dream version, that everyone would understand that right now you should work in a horizontal way of communication, not a vertical one. As they taught and said in those courses. Unfortunately, this is about excellent teamwork, where everyone is aware of their competences…, but how to realise it in practice... difficult, I don't know. Quite a lot of work needs to be put in there by department heads.

4.3.2 Intergenerational communication

Without asking about it or posing any leading questions on the topic, the theme of intergenerational communication appeared in every theme block. This theme emerged in every theme block during dialogues with midwives, not only in the section about communication.

It was talked about as a heavy burden; midwives see problems among midwives themselves not only between midwives and service receivers.

Cupressus: "Well, to be honest, the generational view of things is also a very heavy stone."

There were younger midwives, who did see problems with their colleagues-midwives who had worked in the profession for more than thirty years. They seemed to them unresponsive and not participating in teamwork as actively as they should. The younger ones consider that some of the older colleagues even do not like to be there as midwives, that they come to work just to be there until retirement.

Thuja: "Let's say there are some who have already worked for 30 years and are coming unwillingly, slowly when you call for them. I think they should be fired, so that those who want to come to work and really do it can replace them. Not those who work just waiting for retirement at work, because they are already tired from all this."

Some of the older midwives see problems in young midwives' communication with both them and service receivers. They described it as lack of empathy in the younger generation and an inability to communicate face to face, they see that younger midwives prefer texting to talking face-to-face.

Betula: "I don't know…how can you be a midwife with real empathy. The woman is here right here, you need not to be in your phone all the time; with service receivers, even with your own children. You are a human being with mouth, ears and heart, why don't you use it?!...I don't understand this nonstop texting."

Midwives described complicated situations where different generations and their professional views combine with the extra issue of hierarchy at work, for example a midwife with less experience working with a doctor who has more than 30 years of experience, as the biggest issue with intergenerational communication. Younger midwives, however, talked about how impossible it sometimes is to provide care for a woman in accordance with their knowledge and conscience when the doctor who is senior to them and has more experience continues to work as he or she did 30 years ago, with the same vertical and superior attitude towards
the service receiver.

Padus: "And the biggest thing I remember is when we had "foetus mortus".[20] *As I know how important it is for a woman to see her dead baby and say goodbye, no matter how many weeks old he is, I wanted to offer her this opportunity, but the doctor, who had a completely different vision, just said to the woman: "Why you want to look at it, it will just appear in your*

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[20] Foetus mortus (in Latin) – dead foetus

nightmares!" And that's all she said in front of the woman! Those old doctors work for more than thirty years; they have become entrenched in their beliefs don't consider each case as individual one."

Midwives from an older generation also see it as one of the reasons why, as they see it, the younger generation of midwives are very polite, but from their point of view do not connect so well with service receivers as they do. They perceive this situation in the way that younger midwives consciously or unconsciously maybe it as a way to protect themselves from the non-stop worries and anxieties coming from the service receivers. Reflecting on it further, more experienced midwives also admitted that maybe it is even emotionally healthier for a midwife herself as a prophylaxis against burn out.

Populus: "Well, let's say yes, the generations are different, those who started to work in the last decade, it seems to me that those who are 20 to 30 years old, I think, they don't connect so much to their service receivers. They don't say what they feel to service receivers; they very carefully consider what to say and what not to say. Basically, it is, I think so, it's such a good protection mechanism, if something goes wrong, it's everyone else's blame, not mine. I associate it may be a bit with a moment of conscience, and it makes me a bit, well, careful. So that person does not burn out, does not simply burn out… for him, in fact, such a model of communication is almost kinder to himself."

Midwives of the younger generation reflected on their observations that their older colleagues were reluctant to accept changes to the current communication guidelines. They expressed their understanding that it could be difficult after dealing with things in a completely different manner for several decades.

Cydonia: "It is often generational thing. There are rare exceptions – people who go with the times – but mostly, if she started working 40 years ago, they've worked that way, and everything has come together nicely, and everything has been good. Why should they change anything?"

Midwives openly admitted that they did not see even a possibility of every midwife changing their old-fashioned manner of vertical communication with the service user. In order for that to happen, they would need to work on themselves and analyse themselves, but, if they do not believe that is even possible, there is no point in taking lifelong education courses about communication or the practice of therapy.

Populus: "For those 40 plus people, they have already grown up in a different field of information, so for them it's either a psychologist, a psychotherapist, or a therapist, and now there are many various deviations, it's like that for them … they don't believe them so true, to the end. And if you don't believe that therapy can heal, then it doesn't make sense to even try."

There were a lot of complaints from midwives about the oldest generation of colleagues, referring to their inability to see changes in healthcare philosophy and see things differently because they had been used to doing things a certain way for decades.

Cydonia: "You see, those old doctors and old midwives. Sometimes I think they have this syndrome – I am God, I can help, I can change something, and that's the problem when you can't accept something new afterwards."

Some midwives specifically noted that it is impossible to have a fruitful discussion with the oldest generation of midwives. They do not see them as capable of discussion at all, they feel that those colleagues see it as criticism as opposed to an exchange of thoughts.

Ulmus: "Those before retirement age, there are midwives, I'm not saying that all of them, but some who don't want to object, they don't want to philosophise about anything, as they say: that's what we do and that's it."

Midwives admitted that intergenerational communication has a lot of unresolved conflicts within it. Even just in the type of communication they are different; the youngest ones prefer texting while older ones prefer face-to-face conversation. Midwives admit that a lot of work would need to be done to unify those generations at work. They proposed that the management should do more in this field.

Pyrus: "There are huge differences. There is the Soviet generation, then the one between the times, and then the brand-new generation that is coming in now, which communicates in a completely different way. It is easier for them to write you a "What's up" message from the next room than to come inside to talk. I generally think that it is difficult for those young people to communicate in real life, with real people, real conversations and with empathy, in real, so to speak, but how to achieve that middle ground? I think it's just a lot of work that unit manager should invest in."

Reflecting further on intergenerational communication some midwives concluded that this has very deep roots in our history. As a nation which historically has been conquered by several nations over several centuries, we always had someone else we could blame for our inability and struggles. For a very long time we have been in the role of victim and for objective reasons, for decades we were not able to speak up for fear of being sent to prison, Siberia or forbidden to have higher education at any establishment. In some midwives' view, for this reason, it left people only able to have their true conversations quietly. That is how the term '*kitchen conversations*' was born. This, as some midwives see it, has not disappeared from all people's unconsciousness and they think that generation born after 1990s is the first one who does not have that unconscious fear. This is where they see the opportunity for conflict to arise, as there are those who are not used to saying what they want and to doing everything to get it,

and others are used to saying openly what they think and to doing anything to get what they want, without any fear.

Larix-mill: "If we look historically, I think society has never really recovered once the next danger has started. And there have always been some foreign masters, there are Russians, Germans, Poles, Swedes, who can be blamed on the one hand, but somehow the Latvians have survived, but to be able to survive, every initiative was already killed, you could only survive if you were invisible and inaudible, you didn't stand out. Well, in the same Soviet times – you couldn't say out loud what you thought – then you were sent to Siberia, you could quietly whisper something in the kitchen. And I think that even now, if I look at my grown-up children, they are perhaps the first generation who speak quite freely about what they want and why we also have this conflict in intergenerational communication is this situation. Because the midwives of the older generation are used to whispering quietly in the kitchen but not changing anything. The new generation of women comes with specific demands and there arises a conflict. Those young women, even if they are clients, they don't need to change, the ones who need to learn how to work with them are the medical staff."

4.3.3 Uplifting effect of expression "Thank You!"

The midwives especially emphasised that in all everyday problems and difficulties at work, a huge emotional uplift, inspiration and desire to work harder is given by those two simple words: "Thank You!" It does not matter whether those two words are said personally to you or in a social media post aimed at the whole unit with no names mentioned, it has its lifting effect all the same. The midwives also reflected that it is also important to accept your own contribution, as midwives tend to dwell more on those cases with worse health outcomes. Those simple words of gratitude also serve as a reminder of a 'job well done'.

Malus: "Such simple thing, actually. Families simply write, privately or in social networks, it doesn't matter where – "Thank you, it was a fantastic day! Thank you to everyone who participated" – and that no one are specifically named, but that the department is simply mentioned. It's so heart-warming that they have and have received that support and feel like it was so helpful and lifting for them. You learn to accept your own contributions as well."

After their reflection about problems at work, midwives noted that those words of gratitude from patients and the feeling that their participation helped somebody experience childbirth positively, are sometimes the only remaining reasons why they still come to work.

Salix-alba: "At some point, the only thing that sustains is the patient's: "Thank you!", not a thank you as gift, but a verbal "thank you". When you understand that this one person or one family leaves a little happier than when they came in."

4.4 IV Theme – Legislation and practice

In this theme there were three main themes with subthemes highlighted:

- legal protection and midwifery;
  - protecting yourself;
  - learning possibilities from the experience of other colleagues;
- mutual support;
- lack of real legal or moral support at work;
- disorganised system with double documentation- on paper and electronically;
- unrealised potential of midwifery skills;
  - expressed wish to do more and barriers to this in practice;
- support from the board of LMA is starting to appear.

Midwives not only elaborated on current issues, but also pointed towards possible solutions and challenges that, in their view, are having a hindering effect and are obstacles to moving forward in their professional development and daily performance at work.

4.4.1 Legal protection and midwifery

Protecting yourself

In this theme midwives stressed three self-protection needs: in practice, meaning self-protection through ensuring sanitary and anti-epidemic requirements, legal self-defence and documentation in contested situations and defence of the midwife's competence as a physiology expert.

When talking about self-protection through ensuring sanitary and anti-epidemic requirements midwives honestly admitted that they did not follow guidelines for those issues 100 % of the time. The needs of the woman and newborn sometimes come first. For example, to ensure intimacy and the appropriate release of oxytocin in the woman's body, thinking about the woman's feelings, not all midwives wear protective glasses so as not to destroy the feeling of intimacy. This, in turn, means that there is a high probability that the midwife will get women's urine, amniotic fluid or blood on her face and eyes. Another example might be if the child is born suddenly and unexpectedly, the midwife will not let him fall out but will catch him with her bare hands.

Alnus: "It should be a norm – self-protection, but sometimes when there are some extra situations when gloves are not on … In those situations, I sometimes think more about times the fact that I must do something and help a woman, but you should not forget about yourself, your safety. I still need to remind myself about it, to remember it all the time."

The midwives also described the need for accurate documentation of each of their steps, adding comments when necessary. This is because, in disputed situations, it will be the only evidence in their defence. They also admitted that this is often forgotten in the everyday rush of acting with an individual approach to every woman:

Malus: "And so there is a guideline, where lawyers can point their fingers to every letter and come to a condemning conclusion, which, well, does not inspire you to take action for individualised care."

Midwives emphasised that they see themselves as professionals and experts in the field of physiology, while at the same time, they also pointed out that there is no need to do more than what is within their competence, but you should be able to stand for it professionally. Then, when the treatment begins, the midwives participate but can manage the physiology independently. They feel safe knowing the areas and borders in which their skills lie.

Pyrus: "It's good that there are some frames that are within our competence and that we stick to it. The midwife is, after all, a specialist and caregiver for physiology and not a specialist of pathology."

Ulmus: "I like being able to stand up for myself and say what I think. We are responsible for the physiology. There is no need to interfere in matters where someone else is leading the pathological process."

Overall, midwives reflected that theoretically there is a framework of rules to for legal protection, but, in reality, it is not so concrete and has gaps in it. This is because some points in the legislation are unclear as to whether a midwife can or cannot do something. It could be the case, for example, that a particular manipulation is allowed by the rules, but no midwife with the relevant skills is available on the NHS payment system.

Juniperus: "Framework of rules. I would like to say that the boundaries are a little blurred because we know what we can and can't do, but very, very often it happens that we do more than we are allowed to do or getting paid to do, so to speak."

Learning possibilities from the experience of other colleagues

The midwives emphasised that sharing their professional experience was one of the components of an organised workplace. Regardless of how much experience you have, advice from another colleague is always useful because it is helpful to hear other opinions.

Pyrus: "It helps me that we have an organised environment, that we have colleagues who give advice."

The midwives noted that there are things that can only be learned from older colleagues with a lot of experience. They know methods and professional tricks that are currently not

available in scientific literature and methodical instructions. By knowing modern principles and applying traditionally-practiced skills to them, it is possible to significantly improve midwifery competences.

Cydonia: "Older colleagues can teach you about something. Well, for example, the women's cervix is positioned really far back. As I have a small palm and short fingers, I can't get there, I think: "Oh my God, how do you get there?" and one colleague simply says: "But you spin it with your fingertips like that (showing) – around, then you will get there," and then there it is – "Yes, it works!"

Midwives noted that there is no such time in a midwife's professional career when you feel ready for anything. They said that this profession demands constant, lifelong learning activities and constant learning from other colleagues.

Pyrus: "You must learn all your life. I could say that I gained just some meaning and understanding of midwifery after those five years, so."

Midwives stated that it is not dependent only on a midwife by herself; there should be the correct working environment and colleagues who allow it. There are communication and environmental/organisational work issues involved.

Ulmus: "Whether it is possible, - all depends of the work environment you are in, what kind of colleagues you have. Whether you are given a chance or not."

Midwives also expressed their wish for responsive colleagues on whom younger midwives could lean and with whom they could do their lifelong learning and activities to gain experience. It was described as a necessity in the first years of working to have such an environment. Midwives expressed concerns that if young midwives did not have such an environment, they would leave the profession.

Populus: "I have some midwives, who had said to me: "Whoever needs it, she needs to learn to swim by herself." Well, for example, if a young person enters our midwives' collective, where there are a lot of such old people, then I think there is no place for her."

Mutual support

Some midwives expressed the belief that there would be no unfinished work if a midwives worked in a birth unit taking shifts. There would in this way always be a team to follow who could do what colleagues from the previous team couldn't manage. This should be a normal style of working.

Quercus: "That's why I always remember that whatever, will we manage to do all the work, or we will not do all the work, and surely someone will come after me, after you, after all of us – and work will be done."

Some midwives thought that this would only work amongst midwives from the same generation. That they have unified way of thinking which bonds them together and, in that way, could provide mutual support for each other.

Thuja: "Certainly, colleagues help. Well, of my generation, we have unified thinking."

Some midwives also admitted that they felt most comfortable when caring for physiological processes in the birth unit, with doctors. They felt safe that way because they knew that whatever happened, a doctor, a specialist in pathology, was by their side.

Syringa: "On the one hand, I am very happy that I worked with a doctor, if it is not physiology, but as we know, in obstetrics everything can change, in one minute, two. Then it is important for me to have a doctor next to me. And the important thing for me is that we are a team."

Lack of real legal or moral support at work

The midwives indicated that in several workplaces it was not acceptable to listen to the opinion of the midwife. Whether in discussing care tactics for a particular woman or developing a strategy for a unit, midwives were not required to give their opinion.

Ulmus: "It's a pity that not every workplace has this opportunity and not always the midwife has the right to speak up."

Midwives pointed out the need to introduce the examination of complex cases led by an independent professional in all workplaces, not just in some of them, to stop the current tradition of looking for the culprit. Midwives do not feel legally protected if, while working with a difficult situation, it is expected that the culprit will be searched for later, instead of an objective analysis of the situation taking place.

Ribes vulgares: "Our work does not include discussions about difficult cases. It has been tried, but it never went well because we don't have tradition how not to judge at our hospital. They always find someone to blame. Because there needs to be a professional person who helps to lead this situation analysis without condemnation and looking for the guilty one."

There were midwives who admitted that in some workplaces they did not expect any support at all, neither legal nor moral, because they still had to fight for such simple things as the arrangement of work furniture. There felt that currently there was no possibility even to think about moral or legal support.

Salix-alba: "Oh, what kind of support can we talk about here at all. We got a normal tabletop installed after 12 years! 12 years!... Well, that's how it is."

Midwives noted that they did not rely on the fact the workplace would legally defend them and that they saw it as their own problem or issue. While they did not feel cared for in the workplace, they expressed the need to have this support.

Quercus: "And how long will that employer or boss, or call him whatever you want, remember you when you can no longer come to work for one reason or another. You can rely only on yourself, your common sense."

Thuja: "…, but there must be some kind of frame. As they say, to put it briefly – not to let them to climb on your head."

Midwives expressed their concerns about backbiting in the workplace and the fact that it was acceptable even amongst management. They expressed the feeling of being unable even to hope for that to change, as there is nobody with whom you could discuss it since management themselves are just as much involved.

Ulmus: "Unfortunately for us, the leaders are the same as they are backbiting each other, so we can't ask others to behave differently."

Midwives highlighted the fact that they need to defend themselves, doing it by recording precisely even the smallest issue; conversation, time of calling for the doctor and so on, because, in a case with questionable health outcome, no one, neither the management, the health inspector, nor the prosecutor, are interested in what has been really said or done, just in that what is noted in medical records.

Juniperus: "I would like to say that we work for the prosecutor. Because everything is good as long as it is good, but at the moment when something goes wrong … I would like to live and work that long, when a lawyer answers for me, instead of me answering. A lawyer should answer for me and there should be something, either electronic or something that automatically records our actions. Because when we have a health inspection, they don't care about the person's actions which have been performed, but they only care about the filled in documentation, and if you have not put your signature somewhere…, you are guilty."

The midwives talked about cases when they were held in the role of hostage. As happens in births, sometimes there are sudden complications and the midwife calls for a doctor, but it could be the case that the doctor is busy elsewhere. In this case a midwife has to decide between waiting and having a not good health outcome or performing a manipulation which she should not legally do by herself, even if she is capable of it. It is conflict of conscience as the midwife's priority at work, in her heart, is the wellbeing of both woman and child.

Juniperus: "For my colleague midwife there was a situation that the doctor was busy, and she had to put the vacuum extraction, but it is not really a midwife's competence, because midwifery is physiology and where there is pathology, then the doctor should join. I would like

to say…, you know how I could compare…, that our legislative frame is like Dutch cheese – we have holes in it."

Midwives expressed their regret about the fact that even if there is an opportunity to work with a therapist after difficult cases, especially when it is free of charge as money issues are important to midwives, the management sometimes does not acknowledge it and denies such an opportunity without even asking the midwife's opinion.

Thuja: "We had discussion of such a case in our team at the unit, with participation of a psychologist. In the end, she told me: "You should come to me; we will work it through." And the head of the department replied on my behalf: "What? A psychiatrist for her? She's a strong girl; she'll handle it on her own!" And I thought to myself: "How do you know how strong I am?"

From my own reflective notes about lack of moral support at work for midwives:

"Somehow years go by, but this expression, "the midwife fills in documentation for the prosecutor" still does hold fear for midwives. There are more patient evaluation scores, information sheets, notes of what should be filled in and so on, but there is still anxiety among midwives that there could be a work inspection by the health inspectorate or the prosecutor's office at any moment, not for the work done, but for the documentation completed in accordance with the article of the law.

I don't see how more documentation to fill in instead of open discussions about what is going on and mutual and psychological support, in the already busy midwifery work of caring for mother and child, could improve anything. As longitudinal data from the UK shows that all the developments in management practice, frequent organisational change, increasing performance expectations, closer monitoring and stronger sanctions for underperformance can generate anxiety instead of the intended positive changes (Findlay and Thompson, 2017)."

(Self-reflection from 06.05.2024.)

Disorganised system with double documentation on paper and electronically

Midwives expressed confusion about the unnecessary marking of many things on paper and in several different notebooks, which must be done in parallel with filling out the documentation on the computer. Midwives described it as an absurd situation and a nuisance that creates errors and erroneously or incompletely filled documentation, because a midwife, in addition to her already-many real duties, has to mark everything on the computer and in many notebooks.

Cerasus: *"There is a programme "xxx", there is a programme that runs the food there, but still there are all paper note-books also. For us in reception, I counted once, eight paper notebooks in total to be filled in, eight! Imagine, and then the patients are transferred to the delivery room, there is another paper notebook, then in the postpartum period, there is another notebook, well maybe more. And then there are notebooks for fridge temperature, for narcotic drugs in the safe, etc.! But it could all be just computerised!"*

Midwives pointed out how absurd it was that information is still duplicated on paper and on the computer. This means that inevitably, in the rhythm of work, something is forgotten and not recorded anywhere. This does not allow midwives to maintain qualitative balance of work and private life, because at home they always remember in which file, or in which computer programme a box to fill in has been forgotten.

Salix-alba: "Yes, this is abnormal, why can't you just do your real job with family? Why do you have to write something all the time and write the same thing 100 times, in paper, then in computer and then you have to mark it somewhere there one more time..., and I see that in my colleagues too, not just in me, it creates such tension. You really must think about your employees, not only about patients, and there are also solutions, let's say, in Estonia itself, right next door. A midwife just walks in with her tablet, and she can write down it right there on the spot, immediately. She is not hysterical when at home she sleeps, about what she has or has not written down. There are opportunities to solve it, if the management of the institution wants it to be solve."

The midwives explained that the introduction of electronic-only documentation would not just be more convenient for them,[21] but also improve the quality and safety of perinatal care. Currently, when a woman goes into hospital to give birth, as part of the admission process, she must give the midwife the Mother's Passport, which the midwife must then rewrite on the computer, which is absurd. Everything should be electronic and accessible to all healthcare professionals. Currently, for incomprehensible reasons, the state has not given all midwives access to the electronic results of women's analyses and examinations.

Quercus: "If we finally would have all the documentation only electronically, we could do it all in mutual coordination – outpatient and inpatient! Not this stupid system with something electronically, something on paper. For example, we would have Mother's passports electronically, all the specialists involved would finally see everything and there would be no silly misunderstandings with lost statements or referrals. Now it's like that, you have to believe what a woman says if you don't have the paper."

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[21] Mother's Passport is a paper document / small notebook which contains summery of women's antenatal and health history in general, descriptions or originals of tests and examinations performed during pregnancy

Midwives expressed their regret concerning the current system of medical records and admitted that previously they had hoped that with computers and E-health, papers would disappear, but in fact they felt that the opposite is currently true. They constantly forget something that needs to be recorded, because they always must remember when, where (computer, paper or both) and what to record.

Juniperus: "We constantly check at work whether you have recorded time, whether you have recorded which employee, when you entered, when you took out, how often the daily norm of amount of work was exceeded just for double paperwork! It's simple, well, some years ago I said that when we will have a computerised record, everything will be easier. We now must double everything, everything! In paper and in computer. We live in some pile of bureaucracy and sit at the very top of it... It's all too much!"

Midwives explained how beneficial it would be if they who work in hospital could see the notes of those who work in outpatient clinics and vice versa. There would be a constant exchange of information and a totally different kind of quality and safety of care for woman and child. In that way midwives in a hospital birth unit would know everything about a woman's medical history, not just a one-page summary on one page of the Mother's Passport. Likewise, when caring for women in the postpartum period, healthcare professionals in outpatient clinics would know the course of birth and early postpartum period, not just a diagnosis and a few sentences about any complications.

Quercus: "People who only work in the outpatient sector, they don't know what is going on in the inpatient setting. There is almost no feedback. Just, if only someone calls and scolds you about something they see as not done or done not properly."

Midwives noted that with changing societal attitudes towards the health service in general, there is an urgent need for electronic-only documentation, where it is possible to note everything in real time, so the midwife and everybody in the team caring for a woman and child can be protected. Midwives try to record everything whenever possible, but there is currently no hospital where there are only medical records; there is a mixed system everywhere, with both electronic and paper records, resulting in more mistakes and unrecorded manipulations, consultations and treatment episodes.

Pyrus: "Everything must be recorded immediately, in real time. There are doctors who will just "dump you under the wheels". If it's not actually recorded when precisely you called for him, you won't be able to prove anything there afterwards. After one such case for me personally, I now at least mark it on the record paper of CTG so that you can see the real time. Roughly speaking, I now write down every piece of shit, but it's actually terrible, on the one hand, that you are becoming a terrible bureaucrat ... and one of our colleagues says all

the time: "You're filling in the documentation of histories for the prosecutor." In a way, it's true. It is also necessary to learn that everything must be written down."

4.4.2 Unrealised potential of midwifery skills

In this theme, midwives highlighted two sections:

- the willingness to do more, the barriers to doing so in practice, and the possible reasons why it is not yet being done, due to both insufficient participation by midwives themselves and other factors;
- the feeling that support from the LMA board is starting to be visible in action and more active in representing midwives' interests than before.

Willingness to do more and barriers to doing so in practice

Younger midwives pointed out that many things have been theoretically legal in midwifery practice for many years. However, due to various bureaucratic obstacles or the reluctance of midwives themselves, the full potential is not currently being realised.

Cerasus: "Many don't use the opportunities to learn further and don't meet the requirements that today's obstetrics sets and what it demands, what society wants, so it seems to me that the situation in midwifery is very difficult, because it has changed, but only young midwives know and see it. Well, those who have studied in the last 10 years, who already mostly have higher education, but I think that there is still such a low self-esteem and if we young midwives talk, that we are not appreciated there, that women don't yet know that they can turn to midwives, - most of the older midwives themselves don't know what they can really offer to women, because according to their competences, they can do everything. The state has already allowed it for a long time, but they fear to do more by themselves don't allow it for themselves."

Several midwives justified the underuse of professional opportunities by stating the fact that people still have the Soviet legacy of the doctor being at the forefront of women's care in their minds. This Soviet legacy is made even harder because of adjoint situation with the previously mentioned unfair NHS payment system, whereby the work of doctors is more profitable for healthcare institutions and therefore even if some manipulations are carried out by midwives, in the documentation they are recorded in the doctor's name, so that the facility receives a higher payment for the same service.

Padus: "For the time being, well, honestly, I feel like it's like a doctor's right hand because the midwife does all the hard work. And then the doctor comes and takes the last award, because of the higher payment from NHS to our healthcare facility, vouchers have been already

written in their name not mine. I would like it to be the case that in Latvia midwives can work more individually."

Salix-alba: "Well, very underrated. The potential and resources of midwives in our country are not used at all, because the opportunities that I see midwives have, are extremely numerous. Cost-wise, much, yes, much cheaper than it would be, if to have it done by a gynaecologist. Respectively, there are several positions, one is a legacy from the Soviet years, the other is a very good lobby of gynaecologists in governmental sector."

Midwives point to the display of power by doctors and the strengthening of hierarchy in several healthcare institutions. Midwives say with regret that their young doctor colleagues also adopt this tactic.

Cydonia: "Midwife nowadays… she is unfortunately very limited. Well, I don't know how in other hospitals, but here are a lot of doctors here, especially the new ones, they do whatever they want there."

Midwives indicated that the first place where they could make more use of their professional potential, even starting today, could be in preventative health measures, for example in cervical cancer screening. Several years ago, there was such an initiative, but ultimately nothing was ever started.

Quercus: "What we don't have is preventive healthcare, well no one goes to the midwife to get a cytology, for example, everyone goes to the gynaecologist, but in reality, it's all so basic and so simple. There was an initiative, but we were pushed out."

Midwives expressed their wish to lead physiological births without interventions by doctors. They noted that in hospital settings it was not possible as doctors tend to use their hierarchical power and not allow them to work independently.

Ulmus: "When they take from us the work that we could do by ourselves and don't allow us to do it all. Because I still believe that a midwife can be much more responsible for her actions and everything, all at once. When we work in hospital, we are subjected to what is written on paper. So, under either the managing doctor or the one the on-call, but I could easily manage physiology myself."

There was also the view that every midwife should start by looking closely at herself before asking anything to be changed by others. There was also a call to stop feeling like victims of the situation and to start acting independently. At the same time, recognising that such an honest look at yourself from the outside can be uncomfortable and difficult, because you will have to take responsibility for what is happening and initiate changes that will not always be comfortable and pleasant. The opinion was expressed that perhaps not all people are able to look at themselves from the outside.

Salix-alba: "And it seems to me that every person who, when he grows up and grows out of some selfish phase, should reach a point in his youth when he realises that if it is always the fault of the husband, the boss and everyone else, that probably the fault is not only in them and that something needs to be changed in yourself, but I see around me that there are very few people who get to that point in their lifetime. And then there are very few, who want to dig themselves up and get to that point. I mean, it's not just about midwives. It perfectly reflects our society as it is now. All people expect from everyone else, and don't start with themselves. And in general, in my opinion, our society is quite infantile, so childish and in such a role of victim and is always waiting for someone to bring and give, but not, when I will do it myself."

Some midwives openly stated that it was not easy to start something new and do more work independently. It requires additional courage and the fear of responsibility creeps in imperceptibly. When starting to work independently, often it occurs to you that maybe it is not necessary, and it would perhaps be easier to work as had been done previously.

Pyrus: "On the one hand, midwives can really do a lot, they really know and understand all kind of things, but sometimes it's your personal responsibility, so to speak, whether maybe we're jumping too high here? We're already jumping like that, well then maybe we should stop."

The midwives admitted that working in a new sphere of practice previously not known or done, requires extra effort and causes doubts about their abilities, which are not always easy to overcome.

Corylos: "I like maternity care, I'm a little doubtful about the rest…, no, I still work in outpatient maternity care, I would have to work a little harder with postpartum, but if I would have to, I would need to learn more, but it would take some effort."

The midwives also admitted that it was even sometimes difficult to do things that other colleagues had been doing for 30 years. Sometimes those doubts are so great that the midwife admits that she does not want to do a particular thing at all in her professional career.

Juniperus: "The only thing, I am afraid of water births. I know the theory, but my conviction worries me. Will he really not take that breath under water?! My doubts torment me."

Midwives expressed their gravest thoughts about the current salary and payment system for manipulations by NHS as the biggest disincentive to a midwife working independently. They see two problems intertwined in this situation; the real work done and unfair payment system. Unfair pay refers to where there is no salary increase for midwives as there is for doctors, by the percentage of performed manipulations. This is because many of those manipulations are performed by midwives but still recorded by a healthcare facility in NHS system under a doctors' names, to be more profitable for healthcare institutions.

Ulmus: "The biggest minus is the salary now. Therefore, the first thing to which all kinds of proposals have been written should be remuneration, outpatient remuneration according to the remuneration of gynaecologists, that they are either equal to or very similar. So that it would not be profitable for the hospital to say anymore: "You know, you have to write the doctor's name on NHS coupon, because it is more profitable for us and that's all." Those are the things that really matter."

Talking about previous issue and many more, midwives admitted that they ought to speak up more openly and loudly. They reflected on the fact that speaking about problems was done more amongst themselves rather than publicly.

Cydonia: "I think midwives must grow their own backbone more. More needs to be said loudly and openly."

In addition to this, midwife even had a precise example for double standard in the field of legal liability. They mentioned that there are doctors who do not allow the midwife to care by her own for women in the birth unit during the day, where there is constant control and efforts to speed up the birth process, but at nighttime the midwife is left alone, and she can perform her care process as she sees fit.

Ulmus: "I always laugh with my colleague midwives that it changes at night. When they specially walk around during the day, they really want to intervene and teach you everywhere. If it is night: "You will be able to handle it, yes? You know what, I must have some sleep." Am I such a good specialist only in the nighttime?"

Midwives expressed the urgent need for E-health which should work properly and quickly enough. This should be accessible by midwives and all healthcare professionals who need those data, not only by doctors and some midwives.

Quercus: "Well knowing our E-health… If it works at all, …because just today too, I cursed xxx programme from all ends outside, because I can't open the screenings, because after a while it just hangs up, throws me out and I must log in again. Well, literally that system doesn't work, I don't know what they had there today, but it didn't work!"

Midwives cited excessively long on-call times as another barrier to using midwifery to its full potential in practice. Some midwives expressed their wish to end 24 h shifts in hospital units, as they do not see how it is possible to provide high-quality and safe care for woman and child in that way. They would prefer 6–8 hour shifts.

Thuja: "It is more than clear what we need to achieve within one 24 h shift is for 3–4 people, not 1 person!

Support from Board of Latvian Midwives Association is starting to appear

Despite all the complications, some midwives say the profession has changed in the last couple of decades. Thanks to the activities of the professional association and the midwives themselves, the profession is becoming more recognised.

Ulmus: "The flow of the midwife in her profession has changed a lot in last 15 years, I would say the profession is starting to change. Midwife has become much more present and more sensitive, more skilled, in general. Some kind of spine is starting to appear in midwifery."

Midwives indicated that the results of the LMA board activities are gradually appearing. Of course, there is still much to be done regarding the NHS payment arrangements and midwives' approach to E-health, but there is hope that something will change.

Pyrus: "I understood after the last meeting of the association, that something changes there finally. That we will be able to write the prescriptions, and we will be able to finally send the laboratory referrals. Since little by little it's already moving in the direction it should really be, but of course it's still bothersome. So, still I can't just think that I'll open my own practice for women with free antenatal care. There are still quote system and struggles with NHS payment and contract system."

Some midwives noted that they see that there have been positive changes in defence of midwifery done by the LMA board in recent times. They feel that there have been substantial activities and efforts to speak up for midwives and there are hopes for positive changes forward movement, admitting that they previously did not really believe in the positive impact of associations on the development of the profession.

Ulmus: "LMA board is doing a great job, at least trying to move the prestige of midwifery and the possibility of midwifery in general as such, I think that something will move and in the next few years it could be that there will be a bit more of that opportunity, but the resistance is big."

Larix-mill: "I am very happy about the activities in the association (LMA). If at first, I would say: "What the hell is this?", now at least someone is doing something. It has gone step by step, small step by step, and yet it is already a little better."

4.5 My own conclusions from changing personal prejudices regarding reflective discussion transcripts after each round of interviews

After interview round I:

After the first round of interviews my preconception that a midwife's professional identity core value was to perform the best possible care for every woman and her family changed towards another perspective – their core value is in fact the ability to get on with

a midwife's professional duties while struggling with a lot of bureaucratic, legislative issues and barriers to fluent healthcare access created by both colleagues and patients.

(From my own reflective notes 23.11.2023.)

From my reflective discussion with the consultant midwife after the 1st round of interviews:

"My ideas changed from the fact that the midwife is there to do everything possible for the mother and child to the fact that the midwife fights all the time to be able to do her job at all."

After interview round II:

After the second round of interviews my preunderstandings that every midwife's core value was the ability to get on with a midwife's professional duties while struggling with a lot of bureaucratic and legislative issues and barriers to a fluent healthcare process created by both colleagues and patients changed towards a new perspective; that a midwife wants to do a lot more than they do, but in their struggle with a lot of barriers built up against their possibility to perform professional duties as midwives, they are so tired of this struggle that now they also tend to have high expectations of colleagues, management. They are also exhausted by the behaviour of women and their partners and a substantial level of their unequivocal participation in all healthcare preventive behaviours and performance of necessary actions at the right moment.

(From my own reflective notes 14.03.2024.)

From my reflective discussion with the consultant midwife after the 2nd round:

"The further I went, the more I realised how much midwives expect from others. It changed from the fact that the midwife is always fighting to the fact that she has a lot of expectations from others: from colleagues, from women, from women's partners, from management, from everyone."

After interview round III:

After the third round my overall preunderstandings that the concept of a midwife's professional identity is something unifying for every midwife changed towards another perspective. "On the paper" or in speech – it is defined as unified in its core elements, but in reality, there is much difference of opinion.

(From my own reflective notes 02.07.2024.)

After the third round of interviews my preconception that midwives wanted to do a lot more than they currently did, but in their struggle with the many barriers constructed against their possibility to perform professional duties as midwives, they were so tired of this struggle that now they also tended to have high expectations of colleagues and management, together with how exhausted they were by the behaviour of women and their partners and a substantial level of their unequivocal participation in all healthcare preventive behaviours and performance of necessary actions at the right moment, changed towards another perspective – that midwives tended to have high expectations of the Latvian Midwives Association, direct management and legislative bodies for improving midwives' working conditions and the perinatal healthcare system.

(From my own reflective notes 08.07.2024.)

From my reflective discussion with the consultant midwife after the 3rd round:

"A lot is expected from the association, direct management, legislative bodies. There is also, of course, a midwife who reflects on herself and thinks what she could do differently, but in principle, if you ask: "Well, what could be changed?" there is not much mentioned of what we could change, but more of what 'they', 'those others' could change."

From my reflective discussion with the consultant midwife after the 3rd round:

"I feel that, admittedly in some topics more than others, the theme of the folk tale about the Bear of Happiness is present throughout; in communication, value systems, what is the norm for us at work, what we do or do not expect; in all of this, the idea of the Bear of Happiness is somewhere near. People are tired, poor and unhappy and waiting for the Bear of Happiness and when he arrives everything will be fine, but until that moment comes, they sit and either get angry or cry… but, as we know, at the end of that tale, the Bear of Happiness turns out to be your own will and hard work...

The real reason for this is that everyone has given up and is no longer able to fight for a better life because they are tired and burnt out from working in more than one place in order to somehow pay the bills, but paying for it with their exhaustion, health problems, inability to provide the best possible healthcare for service users and sacrificing time and energy that could instead be spent with family or simply resting so that they could come back to work with renewed strength and energy."

4.6 Summary of the Findings

Overall, four main themes of midwives' perceived professional identity, along with their subthemes and intertwining elements, were conceptualised in this research.:

1 The core elements of a midwife's professional identity

The following three themes were conceptualised as elements which intertwine with the core elements of a practicing midwife's professional identity:

2 Working alongside changing attitudes towards childbirth

3 Communication

4 Legislation and practice

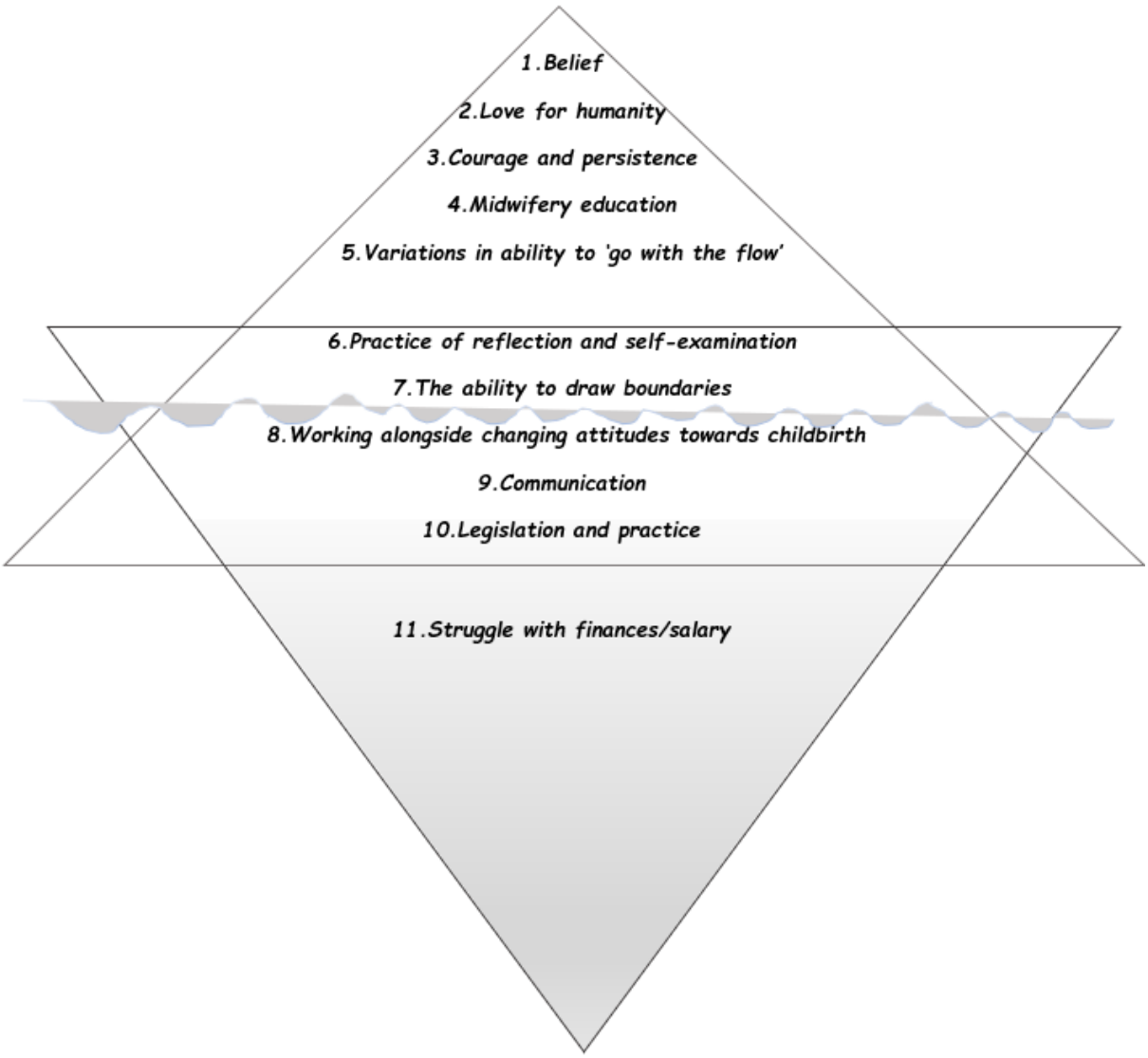
In first theme (The core elements of a midwife's professional identity) – midwives in all three interview rounds described in depth what they perceived as the core elements of a midwife's professional identity. Midwives also described their profession, and the opportunity to be there at that special time, with the family as a privilege. There were midwives who described their profession as something more than just a profession, but as specific way of life or calling. Tools for achieving those necessary elements emerged: courage and persistence, education and professional experience and the practice of self-examination and the ability to draw boundaries. Ever-present and oppressive elements of a midwife's professional identity were identified as overwork and financial struggle.

Second theme (Working alongside changing attitudes towards childbirth) – included a lot of emotional expression while elaborating on it and there were interviews where no questions needed to be asked because midwives expressed their opinion, often emotionally, by themselves.

Third theme (Communication) – in terms of the duration of the dialogues and the amount of text involved, this was the largest theme block in which main three themes and subthemes were highlighted.

Fourth theme (Legislation and practice) – two last themes were highlighted separately, because they permeated the narrative of all midwives throughout all other themes during interviews. Midwives not only elaborated on current issues but also noted points that could help towards both possible solutions and challenges that, in their view, are having a hindering effect and are obstacles to moving forward in their professional development and daily performance at work.

Visually, the elements of professional identity perceived by midwives can be perceived as a piece of ice floating in a clear, but dark, river stream in March (after Ansule et al., 2024). When the sun shines, the visible part of the piece of ice is sparkling and shines brightly in the sun (1. – 5. elements), but there is a larger part that is mostly underwater and only sometimes shines brightly in the sun (6.- 10. elements) and there is even a part that is always dark and icy (11.element) in the cold spring river water and never appears in the sunlight (see the Figure 4.2).



Professional identity concept`s characteristic components in Latvian midwives' perception

1. – 5. present, successfully implementable in practice

6. - 10. partially present, implementable in practice, - but also depends on situation

11. component, which should protect, help the work, but it is a constant hindrance

Figure 4.2 **Professional identity concept's characteristic components in Latvian midwives' perception**

5 Discussion

"To recognise one's own in the alien, to become at home in it, is the basic movement of spirit, whose being consists only in returning to itself from what is other."
(H. G. Gadamer, 2013,13)

In hermeneutic research, the guiding methodology is that text is part of a larger whole (H. G. Gadamer, 2013, 187). I therefore carried out repeated dialogues with midwives, listened to interview recordings while working with theme maps from transcripts and constantly made handwritten, dated notes about my reflections. I also conducted my own interview rounds with a consultant midwife to obtain additional notes on my own prejudices in the interview transcripts and records. This approach follows the methodological order of the hermeneutic research spiral model (See Figure 3.1), (Fleming et al., 2003; H.G. Gadamer, 2013; Maxwell, Ramsayer, et al., 2020). The main themes and my own main changing prejudices are summed up in Figure 4.1 and in the theme maps for each interview round (See Annexes 1, 2 and 3).

In the process of work in the hermeneutical spiral model four main themes emerged:

1 Core elements of the midwife's professional identity
   - love for humanity and belief in God / higher power and a woman's own ability and a midwife's ability 'to go with the flow';
   - variation in the ability 'to go with the flow';
   - professional education and experience;
   - courage and persistence;
   - practice of self- reflection;
   - necessity to get professional and private life balance.
   - As core hindrance, but regrettably constant element of midwife's professional identity in these days midwives noted overwork and struggles with finances.
2 Working alongside changing attitudes towards childbirth
3 Communication
4 Legislation and practice.

Sub-themes within these main themes were broadly present in all three rounds of interviews, while the most prominent ones in a particular round were noted in Figure 4.1.

Having considered the backward and forward integration of the parts represented by individual interviews with the interviews in the last Chapter, this Chapter continues the hermeneutic spiral by subjecting the themes that emerged in the present research to critical analysis in the light of other published research.

5.1 First round, gaining understanding – determined dimensions and horizons

The first round of interviews was most time consuming of all three and during interviews there were a lot of silent pauses. Some midwives honestly admitted that this was the first time that they had really stopped and thought about what they considered to be the core elements of the midwife's professional identity, for example values, norms and beliefs. Midwives also noted that in the course of their everyday work and duties they did not consider how they saw their professional identity. In general, they heard what other people (colleagues and service-users) expected of them and their own thoughts were more a response to the reflections of others. In those moments, the nature of reflection was determined by others' positive or negative reaction to their profession, whether face-to-face, through the media or via someone else's story about them.

Of the three core elements of the midwife's professional identity (values, beliefs and norms), belief required the most reflection and sometimes it was not possible to give answers to these in the first round of interviews at all. For some, an answer came easily and quickly: the midwife's professional identity core belief was a belief in God linked tightly with women's innate ability to withstand childbirth.

In the first round of interviews, it was easier for some midwives to answer and describe the midwife's professional identity in terms of values and norms, but they could not answer regarding beliefs. For them it was easier to talk about beliefs in the following two rounds of interviews.

5.2 Second round, gaining understanding – fusion of dimensions and boundaries

In the second round of interviews, dialogues were more fluent. Answers came more easily and were formulated more quickly by midwives than in the first round of interviews. This can be explained not only by the fact that the topic of the conversation was no longer new, as for some midwives this was their first reflection about their professional identity, but also by the fact that the conversation had already taken place with me before, and its course was already clearer. Two of the midwives interviewed had been making their own written notes between interview rounds, as they reported their need to understand their own perspective on a midwife's professional identity more clearly. As in all three rounds, after initial thematic analysis of all the text from second interview rounds, my own reflections were made on texts and my own changing prejudices were discussed in dialogue with a consultant midwife to determine the dimensions and boundaries of the themes (see Figure 4.1).

Overall, in the second interview round the power of women, belief in God and the unborn child; the norm of being with women as much as needed and the core value being the privilege to be there together in that significant moment with the family. With some

exceptions, there are lot of expectations and complaints: against the order, legislative or institutional; expectations and complaints against students and younger midwives, who come into practical training; expectations and complaints against older colleagues; complaints about women's and their family's overall diminishing innate ability to withstand childbirth. Midwives also described concerns about the impact of information in the media on women's faith in their own abilities to get pregnant, to be pregnant, to give birth and to breastfeed. This should be as natural as breathing, and only sometimes require substantial help, but, in midwives' view, information in the media makes it look like something which always requires medical interventions.

There were only few pretensions about themselves from a professional perspective regarding what should be expected from them personally. There were midwives who admitted that they did not have time or energy to do reflective work on their own professional performance.

5.3 Third round: fusion of horizons and the establishment of trustworthiness

In the third round of interviews, credibility was strengthened and midwives were given the opportunity to familiarise themselves with what was said before. Every midwife was given the opportunity to read their own transcripts. At the beginning of the reading, most midwives expressed surprise at their own style of spoken language and said that they had thought that they spoke in a more formal language style. Some expressed thoughts of a necessity to improve their spoken language style. After the few first pages, midwives started to get used to their chosen style of spoken words and immersed themselves more in the themes than their style of speech. There were some minor corrections suggested which were acknowledged and corrections were made in transcripts. When making comments, the midwives did not ask for any corrections that would change what they had said before about their expressed opinion or described experience, but rather suggested corrections relating to the language style or sentence construction. They made deeper reflections on core elements of a midwife's professional identity and other elements that go along with them (working with changing attitudes towards childbirth, communication, legislation and practice) and made some highlights during last round of interviews.

They also continued to express a need for management, government, LMA and society to recognise the professional output of midwives in healthcare and to improve midwives' conditions at work, especially in relation to wages in the public healthcare sector.

Midwives talked about media output in current trends of childbirth and the need for midwives' professional opinions also to be heard in the media. After initial thematic analysis

of all text from third interview round, my own reflections were made on the texts and my own changing prejudices were discussed with a consultant midwife in order to understand everything more profoundly.

Four themes with subthemes were consolidated in the final round: core elements of the midwife's professional identity and three themes or elements that go along with the core elements of a midwife's professional identity: working with changing attitudes towards childbirth, communication and legislation and practice (see Figure 4.1).

5.4 Core elements of the midwife's professional identity

It became clear that in the perception of practicing midwives the core elements of the midwife's professional identity were love for humanity, belief in God/higher power, women's innate abilities, the ability 'to go with the flow', professional education and experience. This was all intertwined with both subjective and objective influencing factors and conditions (see Figure 4.1 and Figure 4.2). As the authors of the Nordic view of midwifery theories and perspectives (Lundgren Ingela, 2022, 79), emphasised, care in midwifery today should be founded on evidence-based guidelines, but should also involve the context, preferences and values of the woman and her family, and the expertise of the midwife. Midwives described the belief in women's abilities to withstand childbirth by themselves as being intertwined with the ability of midwives to be able to provide such care that women are able to withstand that process. Additionally, in this research and that of previously-mentioned authors, other research and midwifery theories also emphasise that the care of woman and child is not just theoretical medicine, guidelines and facts from health history, but that there is an essential need for psychological and spiritual support (Peters et al., 2020).

Throughout the literature, as mentioned above, the challenges are described in the perception of the professional identity of midwives and the recognition of its core elements in practice. Nonetheless, midwives described their profession as more than just a professional occupation, but rather as a lifestyle, calling or mission in life which they perceived as a privilege and something that they just loved. This love for being a midwife echoes with what midwives have also noted in other continents (Bloxsome et al., 2020; Bogren et al., 2020).

One thing that was expressed as one of the core elements of the midwife's professional identity was the participants' ability 'to go with the flow' (as *Malus, Quercus* in 4.1.1.) and (as *Malus* in 4.1.4.) it was suggested that sometimes this means that they had to be brave in order to advocate for their clients and provide individualised care that was '*out of box*, as it also should involve the context, preferences and values of the woman and her family, and the expertise of the midwife (Lundgren Ingela, 2022, 84 - 86; WHO b, 2021). Participants

described the ideal scenario as their belief in women's ability to withstand childbirth, intertwined with the ability of midwives to provide care that would enable women to withstand the entire process, thus moving beyond theoretical constructs, the biomedical model and facts from health history. Such arguments have also been noted by several midwives (as *Juniperus, Hedera* and *Sorbus* in 4.1.4), but yet have not been used to challenge the dominant models which prevail in health services in Latvia.

Midwives (as *Cerasus* in 4.1.3) expressed their need for persistence to be able to ensure the empowerment of women and to advocate for a woman's own expressed wishes and needs in the whole perinatal healthcare process. Midwives (as *Populus, Tilia* and *Larix-mill* in 4.1.3) also expressed a perception that they have the personal capacity to support a woman's confidence in her own abilities and promote a positive childbirth experience. As is also suggested in the literature, this was described as difficult task, despite their level of education and experience. (Dollarhide et al., 2023; Hildingsson et al., 2023).

There was some diversity in how midwives perceived their roles in terms of the physiological and pathological processes in childbirth. Some midwives (as *Hedera* in 4.1) saw their main professional mission as in providing care and enhancing a woman's ability to do as much as she can by herself within the care spectrum of physiological processes. Others (as *Betula* in 4.1) described how thrilled and positively excited they are when preventing and resolving pathological situations. Likewise described in literature is the diverse perception of midwives themselves according to the healthcare situations they feel able to provide most successfully (Davis, 2012, 7). As noted in literature midwives need to have a wide range of possibilities within their professional judgement and ability to use critical thinking in order to be able to meet all of the various challenges in midwifery (Mong-Chue, 2000).

Nonetheless midwives (as *Juniperus* and *Quercus* 4.1) also expressed their belief that the midwife is a universal professional who can do a lot in healthcare provision and as well as empowering and encouraging women and their families. Midwives described their professional role as being someone who can judge how much they are needed and not impose themselves on others, even with good intentions, which is unacceptable in this profession. As other authors emphasise, the midwife is a professional who is near or beside someone and is trying to encourage and enable this person to do as much as possible by her/himself. (Lundgren, 2022, 109–110; Ueda, 2019). Although it was not intended that this Thesis would explore the Covid period and its impact on core values, midwives (as *Malus* in 4.1.8) discussed it in terms of how it served as a tool for measuring the core values of their professional identity. They looked back on it at saying that in that time it was very clear what mattered most. In that period, in midwives' reflections and other research, in spite of all the difficult and tragic situations, it was possible

to affirm the power and strength not only of women, but of midwives themselves and their team also. (Chapman et al., 2024; Murphy, 2020).

Overall, there were midwives who practice self-reflection (as *Populus*, *Sorbus* and *Larix-mill* in 4.1.5). There were those who have done it sometimes (as *Ulmus*, *Ribes* and *Cydonia* in 4.1.5) and those who admitted that they do not do it (as *Picea, Thuja* and *Corylos* in 4.1.5). While throughout the literature (Bass et al., 2020; Bubnys, 2019; Lybarger, 2024) the self- reflection is described as necessary tool for every professional, midwives expressed that it takes years for them to practice it and try to ensure this balance, but they expressed regret due to very low salaries and the constantly increasing cost of living, they give up their time with loved ones and in order to take on extra work. As found in research carried out in 17 other countries, there were also midwives (as *Thuja*, *Picea* in 4.1.9 and *Salix-alba, Cydonia, Corylos, Cerasus* in 4.2.1) who expressed their doubts and thought that maybe it is not possible to stay in this profession any longer (Jarosova et al., 2016).

When looking at the work and private life balance, midwives with longer work experience talked about warning less experienced midwives about importance of maintaining such balance (as *Quercus* in 4.1.7), as well as the negative effects of night shifts and overwork on family life which is also mentioned in the literature (Dent et al., 2024; Donovan et al., 2021). This is consistent with other research about the importance of working within a legislative agreement which should assist midwives in balancing work and leisure time as occupational stress is increasing in many industrialised countries, and can lead to burnout, job dissatisfaction and an increase in midwives leaving the profession (Fereday & Oster, 2010). In addition to midwives leaving the profession and the personal costs involved, this can negatively impact an organisation's ability to meet the needs of service users and provide quality care, additionally affecting the morale and productivity of the remaining midwives (Schluter et al., 2011).

As in this research, the changes related to midwives' professional attitudes and perceptions after becoming mothers themselves (as *Salix-alba* and *Pyrus* in 4.1.6) are also described in literature, by way of increased empathy and peace while making decisions for best care options (Davis, 2012, p. XI; Skinner, 2023, Ch. 2. p. 11; Yilmaz-Esencan et al., 2022). This personal experience is described as an additional prism for perspective for the midwife when professional experience is additionally illuminated with the midwife's own experience of becoming a mother, thus creating deeper understanding and empathy with what woman are going through in childbirth.

While throughout the literature core elements of being a midwife are also described as a mission in life or lifestyle, something that is more for them than a profession. From that came an acknowledgment that this is some kind of privilege or even an opportunity to enjoy the life

which requires belief in a higher power, women's own innate power and not the risk-focusing pathogenetic professional orientation in healthcare (Aziato et al., 2016; Davis, 2012,XV; Ikhlasiah et al., 2022; Lundgren Ingela, 2022,107). There are elements that stood out in this research in practicing midwives' perspectives on their own professional identity, such as love for humanity (as *Larix-mill* in 4.1.1) and belief in God (as *Hedera*, *Populus* and *Malus* in 4.1.1), as core values in this profession, and these core elements were even described as a leading reference point which guided them to the midwifery profession in general.

The core elements just described above are mentioned by midwives together with their professional experience and judgement (as *Malus* in 4.1.1), and this resonates with any local or international guidelines where the safety of mother and child always comes first (SPKC, 2024; WHO, 2018, 2021). Safety in healthcare does not exclude a respectful attitude and faith in women's innate abilities or a belief in a higher power above humans (Callister & Khalaf, 2010; Clancy et al., 2022; Mutmainnah & Afiyanti, 2019). Any healthcare episode in midwife's practice should involve the context, preferences and values of the woman and her family, as well as the professional expertise of the midwife.

5.5 Working with changing attitudes towards childbirth

In this theme the principal ideas which stood out were disappointment in the undervaluing of the midwife's profession, social trends in childbirth, the medicalisation of physiological processes in perinatal care and changes in the ability of women to withstand the pregnancy and birth process.

Nowadays, even though there are midwives working with bachelor's and master's degrees in healthcare, nonetheless they feel undervalued from the point of view of society and government. Furthermore, as studies in Sweden and Belgium show, nowadays midwives do not feel the need to be ordered about, as they are aware of their own abilities and professional competencies (Hildingsson et al., 2023; Vermeulen et al., 2022). As the findings in this study showed midwives feel that others are not fully aware of their full potential and professional abilities (as *Ulmus*, *Cerasus, Quercus Salix-alba,* in 4.2.1). In addition to that there is so much information about childbirth of differing quality, almost every service user has her own vision about it, forgetting that the midwife is a professional in this field. Likewise, midwives said that they are not servants who have to just fulfil every service-user's wishes but are healthcare providers with robust abilities and wide knowledge in this sphere (as *Ulmus* and *Pyrus*, in 4.2.1). In contrast, as research shows, we see the media field where the highest popularity was observed for the topic of 'Childbirth' immediately followed by the second most popular theme, 'Caesarean section' (Kamiński et al., 2020). The challenge lies not in that society is actively

seeking information about these themes, but that not all the websites have trustworthy information on them (Oscarsson et al., 2018; Vogels-Broeke et al., 2022). This creates the possibility of mistrust between the woman and the midwife, especially in cases where the woman's wishes are in conflict with what is recommended by the guidelines. Additionally, this can create vulnerabilities for midwives associated with fear of reprisals or litigation (Feeley et al., 2019).

In relation to the existing remuneration system, midwives repeatedly expressed their disappointment and regret at being undervalued as people in the field of services where no previous education is required. Midwives elaborated that they are expected to do so much, not only as medical professionals, but also as professionals who could provide coaching, encouragement, even make people feel empowered. However, this is not seen on the other side evaluating the work done, when the work should be appreciated (as *Corylos*, *Cerasus* and *Salix-alba* in 4.2.1). As research in 17 other countries shows this can lead to midwives either leaving the country and seeking jobs elsewhere or even leaving the profession (Jarosova et al., 2016).

Disappointment in the midwife profession also arises from several aspects that are also recognised in international papers: midwives are more likely to be women and so they experience considerable gender disparities in pay rates, career pathways and decision-making power (WHO, 2019, 2021). Midwives expressed their desire for a more supportive environment at work from direct management and in legislation for autonomous practice (as *Cydonia, Cerasus* and *Padus* in 4.3.1) as it is widely recognised in the literature that there is correlation between job dissatisfaction and employee turnover, as well as with quality of care (Brydges et al., 2021). Reflecting on their profession, some midwives (as *Corylos*, *Salix-alba*, *Cydonia*, *Cerasus* in 4.2.1) admitted that at the moment they consider midwifery to be in a very bad state and that they are considering whether it is worth staying in the profession. According to findings in the literature this is not due to the actual job, but rather to other related, contextual and environmental factors that make it so stressful. This has led to the contemporary midwifery environment of practice being described as "war-like" and the consideration that the job is not worth it (Geraghty et al., 2019).

Midwives openly talked about the importance of standing up for themselves and using freedom of choice (as *Ulmus* in 4.4.1 and *Salix-alba* in 4.4.2); they compared it with the old Soviet regime, where after midwifery education you were supposed to work for several years wherever you were sent, but now when you have free choice, you can even not work at all. They stressed that then it was forbidden, while now it is norm – you can choose to work, not to work, work part time, and so on. As suggested in the literature, women theoretically have freedom of choice regarding the amount of work, but they still do more housework and

childcare (Fine-Davis, 2016; Gietel-Basten & Verropoulou, 2018). The element of their still doing more at home/family raises more questions: do women really have full freedom of choice and do women exercise the full potential of their freedom of choice? Midwives highlighted that it also makes one be responsible for your own choices and change what you don't like: you are not supposed to be a victim of the political or economic regime anymore (as *Salix-alba* in 4.4.2), you need to go with the changes and change yourself along with them. The midwives' reflections resonate with what is described in the research, where working conditions, including low wages, are the reasons for moving to another country and continuing professional activity as a midwife elsewhere (Jarosova et al., 2016).

Reflecting on social trends in childbirth, midwives noted that in their view the responsibility of the whole family is diminishing (as *Padus*, *Salix, Thuja* and *Syringa* in 4.2.1). People like to listen to a lot of podcasts and attend courses, and midwives feel that people need more instructions rather than conversations with midwifes (as *Pyrus*, *Larix-mill* in 4.2.1). As suggested in the literature fewer and fewer young families listen to themselves and their inner beliefs. They somehow do not want to take responsibility and make choices, but want to have more instructions and are less inclined to enjoy the difficult, but beautiful physiological process of childbirth (Junaid et al., 2024). In the findings of this research, as in the literature, some midwives (as *Malus*, *Salix-alba* and *Populus* in 4.2.1 and *Cydonia* in 4.2.1) expressed the opinion that nowadays, when women educate themselves over a longer time period, work more and have different patterns of family life than previously, it is inevitable to expect that some women will lose their innate ability for childbirth (Erfani & Beaujot, 2009; Kim & Cheung, 2015; Yucel, 2015).

In their reflections on the medicalisation of the physiological processes in perinatal care, midwives openly stated their disbelief in the latest birth induction guidelines (as *Quercus*, *Picea*, *Pyrus* and *Thuja* in 4.2.2). Their answers on this didn't need any second thoughts before answering. The midwives' distrust in the medicalisation of childbirth, especially in terms of the rising numbers of birth inductions, is widely described in the literature, as it goes against their professional experience, woman-centred care, and the fundamental principles of holistic healthcare approaches in general (Lundgren Ingela, 2022, 37; Raoust et al., 2024). The common theme in this research findings and other studies is the absence of reasoning and evidence for the need to raise induction rates, as it makes women feel unable to connect to their innate ability and takes away the elevating power of birth process.

As in the literature, also in this research, midwives highlighted concerns and reflections on the disturbing effects of CTG recording and other interventions in a physiologically progressing birth and the disturbance of opportunities to ensure intimacy during birth, without

the observation of other colleagues and unnecessary interventions (as *Cerasus, Picea and Cydonia* in 4.2.2). As other research shows, this also prevents the midwife from working autonomously in the care of physiological processes (Brydges et al., 2021).

5.6 Communication

This was the largest theme in terms of the amount of text in findings, and within it main two subthemes were highlighted: influencing factors of communication and intergenerational communication.

Midwives expressed different approaches to communication as such; there were midwives who pointed out that the main thing is not colleagues, but midwife's own ability to do everything possible to provide women with a positive healthcare experience, no matter what, as communication is an essential part of every contact we undertake (as *Populus*, *Alnus* in 4.3.1). As suggested in the literature, in previous decades and also today, the care of women and children is driven by an overall goal of safe and affordable care, while implementing a lot of scores and protocols, thus constantly increasing the work of midwives with filling in documentation, further limiting the time busy staff have to talk to a woman about how she is feeling (Bick, 2010; Mutema et al., 2024; Ormiston & Schrift, 1990a). There are initiatives to make the care process more humane and respectful, but these do not diminish the paperwork load (WHO, 2018). Paradoxically, one has to return to articles written in the past that already warned about the shadow side of over-documentation. The overload of protocols and the diminishing of individuality are explained by Max Weber's thoughts on the so-called 'iron cage' influence on the service relationships, which he expressed 100 years ago, where it is the files that dictate what must be done, rather than the individual needs. (Gubrium et al., 2016, 57; Maley, 2004).

As the midwives highlighted, there is a significant issue of human nature in that it matters who you work on a particular shift (as *Cupressus, Alnus* in 4.3.1), regardless of their professional specialism. What matters is their true nature as a person. This is consistent with the findings of a study on collaboration in maternity care in the Netherlands, which found that having a cohesive team with understanding and supportive colleagues is the key to satisfaction with one's current job and specific workplace (Cronie et al., 2018). The supporting shoulder of a colleague and mutual help is significant. Inefficient communication arises when an individual who would normally perform professionally and efficiently at work, starts communicating in a way that disregards current professional and ethical norms (as *Cydonia, Padus, Salix-alba* in 4.3.1). Optimal collaboration between professionals involved in the provision of healthcare is known to be a critical element of safe and effective care.

Another issue is that each maternity care professional has a different understanding of what collaboration means in practice. Midwives expressed the opinion that communication demands continual learning with an individual approach and that different colleagues and different women will always surprise you (as *Betula* in 4.3.1 and *Cydonia* in 4.3.1 and 4.3.1), because every human being has their own world view. There are findings in literature which highlight that doctors pay more attention to giving information, while midwives spend more time with patients in general, and also spend more attention and time on being able to understand the patient's perspective. Adding to this, there is still a strong sense of the doctor/midwife hierarchy in the workplace (as *Syringa*, *Populus* in 4.3.1), which also corresponds with findings in this Thesis - when doctors or direct management tend to give orders for care without consultation with midwives (Watson et al., 2012). Throughout the literature communication, inter-disciplinary collegial relationships, and managerial support are described as crucial to sustainability and increased job satisfaction and an enhanced sense of autonomy in the profession of midwifery (Styles et al., 2020).

Midwives expressed their need to be heard in workplace and for their views to be taken into account when decisions are made (as *Malus* and *Thuja* in 4.3.1). Mutually successful communication is important, not only for midwives' satisfaction, but also because a supportive work environment is associated with decreased burnout and attrition, and increased job satisfaction and employee health. (Thumm & Flynn, 2018). There is a need for open dialogue between midwives and doctors, midwives and management, and midwives and the government, rather than a system based on orders from above. As other research shows, policies governing interprofessional practices must result from genuine and honest dialogue that makes power relations among relevant interprofessional groups transparent and proposals for action adaptable (Brydges et al., 2021).

There are compulsory lifelong education courses in communication for everyone working in perinatal healthcare in Latvia, but, as literature emphasises, there should be more work done on how healthcare facilities prepare, monitor and sustain interventions in order to support effective communication (Chang et al., 2018). Throughout the literature, effective communication is a key factor for safe care, service-users' satisfaction with received care and the sustainability of workforce in current workplace (Kozhimannil et al., 2015). Theoretically, this should be understandable for everyone, yet the findings of this research highlight communication problems on the part of the professionals responsible for the health of both mother and child. Nowadays patients wish to receive emotional support and satisfactory communication with every healthcare provider, as well as acknowledgement that they have been heard and their wishes have been noted (Makarova et al., 2024).

In regard to communication via online resources in healthcare there are reports that online medical consultation sometimes is more convenient for patients than face-to-face visits (Gong et al., 2024). Midwives admit that women like online communication, but in this context midwives also express their concerns about women subsequently accessing further information online, after conversations in texts between a midwife and a woman (as *Pyrus, Populus* in 4.2.1), and whether this information could be taken out of context (Wakelin et al., 2022). Another concern of midwives is about managing their work and private life balance in this type of communication (as *Thuja* in 4.1.7). While it is convenient for women, midwives expect women to respect their working hours and personal time (Wakelin et al., 2023).

The theme of intergenerational communication during dialogues with midwives emerged in every theme, not only in the communication section. It was talked about as a heavy burden (as *Cupressus, Betula* and *Cydonia* in 4.3.2). In theory, the core norm of love for humanity, as expressed by midwives in their perception of their professional identity, should also apply to their acceptance of their colleagues' beliefs and norms in healthcare. As described in the literature, the process of acceptance of others involves ongoing, lifelong self-evaluation and critical reflection, as learning about the health beliefs of another person's culture is insufficient without concomitant changes in our own attitudes and beliefs (Murphy & King, 2013). Nonetheless, younger midwives do see problems with their midwife colleagues and doctors with more than 30 years' work experience, in that they are not responsive and do not participate in teamwork as actively as they should (as *Thuja, Padus* and *Cydonia* in 4.3.2), and they do see problems between midwives and doctors themselves, not only between midwives and service users. On the other hand, some of the older midwives see problems in younger midwives' communication with them and service-receivers (as *Populus*, *Pyrus* in 4.3.2). They described this as a lack of empathy and an inability to communicate face-to-face in the younger generation. The literature also suggests that younger midwives do prefer texting to face-to-face conversations (Anderson & Morgan, 2017). Midwives also expressed concerns about gradually moving away from face-to-face contact with service users and the increased habit of communicating by text to receive exact plans instead of consultation. These findings are consistent with data from other studies, which generally show that service users need more detailed explanations of situations and possibilities, especially first-time mothers (Danhausen et al., 2022; Wyles & Miller, 2019).

In the literature, there is a reported need in for training in communication and evaluation, in order for professionals at work to be able to work together on mutual goals, respecting each other's expectations, intentions, wishes, and beliefs (Siegle & Roes, 2022). This highlights the importance of offering more intergenerational training and formal mentoring programs that

focus on ways to change hostile interactions, enhance intergenerational communication, and create a space for structural changes to take place, so there can be more collaboration between younger and more experienced midwives. The findings of this research also revealed positive examples of good collaboration and learning from each other in the experience of some midwives (as *Pyrus, Cydonia* in 4.4.1), thus promoting a productive and safe environment and mutual competence development rather than an atmosphere of blame and punishment (Anderson & Morgan, 2017; Bloxsome et al., 2020). The exchange of experiences can help midwives cope with stress and normalise their private and work lives from the beginning, learning from the experiences of others (Donovan et al., 2021), and midwives appreciate this sharing of experience in balancing work and private life (as *Quercus*, *Thuja* in 4.4.1).

Some midwifes also highlighted ethical issues regarding the most recent political situations. Due to political events, it is strongly advised that the Russian language should not be used in communication, with the only exceptions being when working with women and families from Ukraine (as *Larix-mill* in 4.1.3). In some healthcare institutions the use of the Russian language has been forbidden by special order. An additional bureaucratic obstacle arises in the already psycho-emotionally complex work of midwives when a midwife has to care for a woman or family who have escaped Russia and don't speak Latvian or English. As is found in the literature, midwives described their sense of compassion and love for humanity, and God as the main guide in such ambiguous situations (Menage et al., 2020; Yilmaz-Esencan et al., 2022). As most midwives more or less know the Russian language, they feel that their first obligation is to give the best care possible to women despite orders or politics.

5.7 Legislation and practice

In these themes, midwives stressed their self-protection needs; in practice, self-protection by ensuring sanitary and anti-epidemic requirements, legal self-defence and documentation in contested situations, and defence of the midwife's competencies as a physiology expert.

Throughout the literature, communication issues between different healthcare institutions, such as weak referral systems, are highlighted as resulting in significant delays in managing obstetric emergencies (Danhausen et al., 2022; Owen et al., 2022). However, this research identified a unique problem: midwives expressed concerns about their ability to access E-health independently and the patient information it contains. Local health services have granted access to E-health only to doctors and some individual midwives, thus making it impossible for every midwife to access any health information about women. They are only able to see the paper form 'Mother's passport' and printed records if a woman share them with

her midwife (as Quercus in 4.4.1). Even the parts of E-health that are theoretically accessible to midwives often don't work or work slowly and inefficiently (as Quercus and Cerasus in 4.4.1). This situation makes it impossible for work shared between different healthcare professionals, involved in care for women and children, efficient and safe.

According to the findings, midwives pointed out the absurd situation that information that is still duplicated on paper and on computer (as *Cerasus, Juniperus, Salix-alba, Pyrus* in 4.4.1). This situation remains just to be safe and to ensure that everything is recorded for fear of possible legal issues. This means that inevitably, with an already heavy workload, something might not be recorded somewhere by mistake. This does not allow midwives to maintain a qualitative balance of work and private life, because at home they remember which file or which computer programme box or something was forgotten. As described in literature, the element of work-related psychological distress in midwifery populations does not receive enough attention, and more research work should be done on evaluating the seriousness and prevalence of this issue (Pezaro et al., 2016). Similar issues have been reported elsewhere in an attempt to reassure and guarantee a degree of certainty, but clinical governance and risk technologies introduce further uncertainties, simply because the goal of colonising the future in this manner can never be fully realised (Alaszewski and Burgess, 2007; Scamell, 2016).

The younger midwives pointed out that many things have, in theory, been legally allowed in midwifery practice for many years. However, due to some bureaucratic obstacles or the reluctance of midwives themselves, the full potential is not used at the moment. The midwives openly stated that it is not easy to start something new and to do more work independently, as it requires additional courage and the fear of responsibility creeps in imperceptibly. In the findings of this study (as *Juniperus, Thuja* in 4.4.1), as in others studies, midwives honestly admitted that they are not always sure about all the legal issues in their work area (Kruske et al., 2013). Several midwives justified the unused professional opportunities by the fact that people still have the Soviet legacy in their mind with the doctor at the forefront of women's care (as *Cerasus, Salix-alba* in 4.4.2), as well as the unfair NHS payment system, where the work of doctors is more profitable for healthcare institutions, and therefore even if some manipulations are carried out by midwives in the documentation, it is noted with the doctor's name (as *Padus* in 4.4.2), so that the facility receives a higher payment for the same service.

Legislation in midwifery was described as cheese with holes in it (as *Juniperus* in 4.4.1). Disappointment was expressed regarding the way direct management behaved. For example, there were cases when the health institution management offered a consultation with a midwife (even free of charge), but the direct management rejected this proposal,

answering for the midwife without asking her opinion (as *Thuja* in 4.4.1). In the literature, a need is highlighted for collaborative cross-disciplinary strategies to prepare midwives for the contemporary medico-legal landscape (Alexander et al., 2021; Wahlberg et al., 2019). Midwives who had experienced clinical investigations expressed their need for reassurance from colleagues and professional psychological help during those times (as *Ribes vulgares* and *Thuja* in 4.4.1).

According to findings, situations were described when midwives were effectively held hostage. As sometimes happens in childbirth, there can be sudden complications and the midwife calls for a doctor, but the doctor is busy elsewhere, in emergency surgery or dealing with other life-threatening birth complications with another mother and child. The midwife then has to decide either to wait and have a bad or grave health outcome for the mother, child, or even both, or perform a manipulation which she should not legally do by herself, even if she is capable of doing it (as *Juniperus* in 4.4.1). This is a conflict of conscience as well, as the midwife's first priority at work in her heart is the wellbeing of the woman and child, but there is also the risk of legal punishment. As suggested in the literature, after this kind of situation, which are rare, midwives admit that they have a long periods of doubt about their chosen work place and their further work as a midwife (Robertson & Thomson, 2016).

Throughout the literature, there are descriptions of the benefits of the safe and fast exchange of information between healthcare professionals of different sectors, as this not only increases the safety of mother and child, but also protects healthcare workers legally (McCool et al., 2015; Xu et al., 2008), it is as yet not the reality. As findings showed, midwives elaborated on how beneficial it would be to have shared electronic records among health specialists. If those who work in a hospital could see notes from those who work in outpatient clinics and vice versa, there would be a constant exchange of information and totally different kind of quality of care for women and children. In that way a midwife in a hospital birthing unit would know everything about a woman's medical history, not just the summary on one page of the Mother's passport (as *Quercus* in 4.4.1). Additionally, a healthcare professional in an outpatient clinic when caring for women in the postpartum period would know the course of birth and early postpartum period, not just a diagnosis.

Midwives expressed that they want to lead physiological childbirth without interventions by doctors, but it was highlighted that in hospital settings thus is not possible, as doctors tend to use their hierarchical power and do not allow them to work independently (as *Salix-alba, Cydonia, Quercus, Ulmus* in 4.4.2). In international guidelines, the midwife is acknowledged as the best possible healthcare provider for a mother and child in the physiological field of health (WHO, 2019, 2021), yet midwives still have to struggle to

provide healthcare independently. There are common barriers for the midwife's independent work described in the literature which resonate with this study: lack of female empowerment; professional barriers associated with professional disrespect and a perceived lack of authority by midwifery personnel; lack of government commitment; low wages; work environment (Everly, 2012; Filby et al., 2016).

In regard to the activities of the Latvian Midwives Association in the last few years, midwives noted that there have recently been positive changes in LMA board activities (as *Ulmus, Pyrus, Larix-mill* in 4.4.2). Midwives felt that there have been substantial activities and effort made to speak up for them and so they are hopeful for positive changes moving forward. Those aspects are related to the continuous desire of midwives to function and develop further as professionals (Avery et al., 2010).

5.8 Fusion of horizons

This research described overall unity among the midwives in the context of their perceived core elements of the midwife's professional identity. In their perception, core elements are:

- love for humanity;
- belief in woman's own ability and God / higher power;
- midwife's ability 'to go with the flow';
- professional education and experience.

As necessary core tools for achieving those elements arose:

- courage and persistence;
- practice of self- reflection;
- necessity to get professional and private life balance.

As core hindrance, but regrettably constant element of midwife's professional identity in these days midwives noted overwork and struggles with finances. There is research done almost ten years ago which describe this problem even deeper not just as overwork by itself (Group and Mander, 2016). The authors describe the opinion expressed by midwives that it is possible that for some employers it is not that important to provide high-quality healthcare, which further causes a chain reaction in terms of workload, work organisation, and work relationships. An in-depth study should also be conducted from the perspective of the midwives' employers.

However, diversity arose in the very process of reflection on the midwife's professional identity, with some midwives admitting that they were reflecting on it for the first time in their professional life. For some midwives it took considerable effort to define in precise words those

core elements of professional identity, as it was sometimes possible to find the right words only during the second or third rounds of interviews. On the other hand, there were midwives who answered this question quickly and without much thought the first time, only re-examining it in depth in subsequent interviews. It should be noted that, in terms of the amount of time spent in the conversations with the midwives, most of the time was not taken up by their perceived prejudices about the midwife's professional identity, but by the explanations given by the midwives regarding what prevents them from fully applying or experiencing these elements in practice. There was much reflection in every interview about the barriers made by others as well as the midwives themselves, which prevent these core elements of a midwife's professional identity from being fully utilised in practice. At the same time, it should be noted that in Latvia there are no gender barriers or money issues to gain qualitative midwifery education and became professional midwife in full it's meaning as this is free of charge, as the state guarantees a certain number of free study places each year. There are no barriers that would prevent one from becoming a midwife who is able to recognise and practice the full spectrum of professional identity, knowing that such barriers still exist elsewhere in the world (Hasne and Zohra, 2019).

Overwork and overload at work, working in several workplaces, tiredly rushing from one shift at one workplace to another workplace for the next shift, does not allow midwives to realise all their professional potential, which they theoretically describe as core elements of midwife's professional identity. In addition, overload and potential errors in work are caused by the documentation system in both electronic and paper format, which sometimes duplicates what has already been recorded in one or other system. All this is only worsened by the NHS's decision not to allow all midwives to access patient data in E-health. The situation is made more dramatic by the ever-increasing demands for an individual approach and time resources from service users and their relatives, which is additionally reinforced by the regulations of the Cabinet of Ministers on the mandatory number of courses in life-long education for every midwife. These courses should theoretically promote perinatal healthcare, but they are not included in the paid work time of midwives and must be done in their free/personal time which is already being eroded by their workload. To make matters worse, sometimes they even have to pay for these courses themselves. The midwives expressed their regret that with all these increasing demands on their professional performance, it is not reflected in their remuneration, which, according to them, is comparable to the remuneration of employees without a vocational education. This resonates with research done already more than 20 years ago (Thompson, 2002) about reality of midwives and human rights, but we are still there according to findings of this research. An in-depth study of the situation should be conducted to see how human rights and labour law norms are respected in midwifery work.

There were midwives who also saw the root of the problem in the fact that historically we have been trained not to stand out in order to survive under the 'yoke of another conqueror'. However, this does not justify the unfairly low remuneration system, when midwives sometimes report that even at home in family, their work is not properly respected, but perceived as a hobby, because it does not receive any serious pay.

Considering all the narratives gained from these conversations with the midwives, the main message that emerges are the core elements of professional identity perceived by the midwives in connection with love for humanity, faith in God or a higher power and a sense of mission in this profession, which suggests that it is also a possible reason why, despite every hardship, midwives continue to work. Also, it is possible that some midwives do not carry out self-reflection due to an instinct of self-preservation, so that it is not so painful to admit how difficult it really is. Thus, they work, perceiving their work to be a mission and a way of life and do not leave it in spite of the possibility of having better pay and working conditions in another profession. This, in turn, does not allow them to insist loudly enough on their demands for midwives' rights to fully realise their professional potential and receive a decent salary. However, we must also take into account the fact that midwives are constantly overworked and in a daily struggle to earn a living, so they may no longer have even the will or strength for such a struggle to fight for their rights.

Conclusions

"In fact, being outside oneself is the positive possibility of being wholly with something else. This kind of being present is a self-forgetfulness, and to be a spectator consists in giving oneself in self-forgetfulness to what one is watching. Here self-forgetfulness is anything, but a privative condition, for it arises from devoting one's full attention to the matter at hand, and this is the spectator's own positive accomplishment."

(H. G. Gadamer, 2013, 128)

There is a diversity in midwives' perceptions of the core elements of their professional identity, as well as their ability to define it. There were midwives for whom answers on their professional identity came right away, but others were only able to define it in the final interview rounds, as they honestly admitted that it was not something that they had ever previously thought about. Midwives agreed on a number of core elements in the midwife's professional identity: love for humanity, belief in God / higher power, the ability 'to go with the flow', being with a woman as much as she needs, professional education and experience, courage and persistence, as well as the negative factors of low wages, overwork, communication issues in the workplace, unused potential of midwives and medicalisation in childbirth. Diversity, however, was found in their belief in women, as some midwives noted that they had a stronger belief in the unborn child and trusted the patterns of his behaviour more than the woman's.

There is also diversity in the perceived role of midwives in healthcare processes. Some midwives noted that they saw themselves in the right place professionally when caring for physiological processes, but there were others who noted that they were thrilled and even loved to work in action, when dealing with active birth management and pathological healthcare cases.

This diversity is also seen in midwives' beliefs. Here the answers came quickly, without thinking, and sometimes without even being asked, as each midwife linked this closely with her professional identity. There were two different groups in context of belief: those midwives who freely emphasised their believe in God and those who described a belief as something that is hard to define like belief in a higher power.

When reflecting on their professional roles, midwives suggested possible ways to fight every negative factor facing the midwife's professional identity expression in practice, such as communication issues at work, wages in public healthcare sector, overwork and the medicalisation of childbirth. In all cases, the need for midwives' voices to be heard emerged. Two different approaches to dealing with these negative factors were expressed. Some midwives mentioned feeling a personal need to defend themselves, while others felt there were midwives who noted that direct management such as the government should behave differently or do more and not midwives by themselves.

Midwives also concluded that there is a need for more actual midwives' voices to be heard in the media. There are many controversial and even frightening stories about childbearing being reported, but very little is heard from the midwives' professional perspective on these stories. This also is relevant with regard to the need expressed by midwives for their voices to be heard regarding the recent shift from a physiological and humanistic approach to the current trend of medicalisation in childbirth.

As women now have easier access to higher education, better career prospects and expect a higher quality of life, but simultaneously have to balance more hectic lifestyles, greater demands on them at work and the media is promoting anxiety regarding childbirth, some midwives believe that it is inevitable that some women will lose their desire to have children.

There are issues expressed regarding mutual communications between different generations of midwives and between midwives and doctors, midwives and service-users. The issue of communication requires immediate action and a willingness to cooperate on all sides, not just waiting for 'others' to do better and change their patterns of communication.

The issue of low wages for midwives in the public healthcare sector, which consequently leads to overwork, also needs to be addressed urgently. This not only has an impact on the welfare of midwives, which is undeniably important, but also on the safety of mothers to be and their babies. Exhausted healthcare professionals running from one 24-hour shift to another can make potentially fatal mistakes and so this issue must be addressed honestly and seriously.

At this stage of research my conclusion is that however wide the range of perspectives expressed by practicing midwives regarding their professional identity and its core elements, it should also be noted that they are humans, with varying beliefs, experiences, attitudes, knowledge, professional and personal perspectives of childbearing and life in general. By projecting so many necessary professional skills, competencies and skills and sometimes unrealistically idealised expectations on midwives, it is easy to forget that they are also human beings, each with their own personality, characteristics and uniqueness. Humans are not creatures that can be characterised as objective or homogeneous. However, midwives do agree on some of the core elements of their professional identity such as love for humanity, belief in woman's innate ability, ability 'to go with the flow', belief in God / higher power, professional education and experience, courage and persistence. There is also unity in perceived negative factors working against the successful professional activity of midwives today: poor wages in public healthcare system, which leads directly to overload due to the need either to work in more than one workplace or to take on more than one workload in one workplace; communication issues at work; rise of medicalisation in childbirth. Overload of work,

communication issues and the unused potential of midwives should not be considered as separate problems, as no human being who has been constantly overworked for years or even decades, is not capable of the reasonable revision and division of their work, effective and empathic communication in long term or the effective improvement of their abilities and professional performance.

Midwives expressed their positive attitude towards recent actions of Latvian Midwives Association's work to defend and promote midwifery and their rights to implement in everyday practice core elements of midwife's professional identity. At the same time, they highlighted their worries about everlasting unjust payment system for their work done and barriers to work in one and easily accessible electronic system for every healthcare provider involved in women's and child's care.

Considering everything written above, the following questions arise:

If midwives were not so overloaded in their workplace, could it subsequently enable them to realise into practice the basic elements of the midwife's professional identity? If there would be no necessity for more than one job to earn a living and there would be just a single electronic documentation system available to all, so that it really was possible to work properly and as a midwife in just one job with a workload of no more than 40 hours a week, would there be so many issues with communication and unused midwifery professional potential as midwives have described in this research?

One area for future research includes the exploration of perceptions held by stakeholders in perinatal and reproductive healthcare regarding the professional identity of midwives. This might identify possible obstacles from the legislative sector to identifying the unrealised potential of the work of midwives in maternal, child and reproductive healthcare. It is possible that not everyone in the legislative sector even knows how wide the competencies and skills of a midwife are.

Open-mindedness is as essential for every midwife today, just as much as all learned professional competencies, skills and knowledge. Not only is the average number of women giving birth for the first time changing, but there is now an overabundance of information available about childbearing trends. It is the woman who should have the final say in that matter, what will be the new version of 'going with the flow' in her own childbearing process (Downe et al., 2018). Here the midwife's true capacity for love for humanity in practice and the ability 'to go with the flow' in women's defined way of that flow really comes into its own.

The need to be able to have this open-mindedness goes even further. It is not limited only to being aware of ever-changing childbearing trends in society, it is also needed at every step of the further development and existence of midwifery: the unused professional potential

of midwives; dealing with challenges like medicalisation of birth; intergenerational communication among midwives; midwives' wages in the public healthcare sector; finding opportunities to take the midwives' voice into account when creating care plans and next steps for mother's and children's healthcare. This all needs an open and creative attitude. Most of all, this needs a willingness to do something and the ability to mutually agree and act proactively for a better professional situation for midwifery from each midwife herself, without expecting that somebody else will come and miraculously will resolve all the aforementioned issues.

If all this is added to insufficient evaluation and support from management, society and legislators, the only logical reasons for midwives still to be working seems to be their feeling that being a midwife is a vocation or mission, their belief in God / higher power and their belief that at least women and newborns still need them.

From my own self-reflective notes about current midwife's professional identity in perspective of practicing midwives:

Overall, the current midwife's perceived professional identity in the perspective of the concept of practicing midwives could be depicted as people's activities by the sea in a nature park. Where sea and seaside could be the health of women and child. It was here before all those people and will be here long after those people… so the main goal should be to preserve it. There are a lot of fallen trees, trees washed out by the see, tree logs, algae and all kinds of wonders…

Where in theory, people understand how unique this place is and how privileged they are to be here and experience all of this, but the cost of living doesn't allow them to experience this in one place, forcing people to divide their time and energy among different beaches.

People here could be depicted as midwives. The majority of them are not able to use, feel…everything that the sea and the beach provide, as they are exhausted from nonstop trips from another beach and are anxious to behave properly as every beach order demands. There is also a nonstop feeling of guilt and a desire to get on finished in time to have some hours at home with the family and then again get back to one of the beaches where they are expected to be. Sometimes they can't even spend time at the beach in peace because they're constantly on the phone coordinating their children's lives at home, because after this beach they won't be able to go home because they'll have to go to another beach.

Some people are playing with all that and relaxing, swimming, with no special equipment. Some are able to relax only with special devices they have taken with them: parasols, bathing suits, buckets and paddles for children, etc. Some are feeling comfortable

with each other; some are thinking that those people without special relaxation equipment or vice versa are not quite normal. There is a feeling that there is no mutual unconditional acceptance towards those who relax by the sea differently.

Then there are some employees from local municipalities who think that this all should be more properly "arranged in order", making plans and special rules for behaviour by and in the sea with no consultation whatsoever with people who are at that beach and can see the full picture.

Could those people just have one beach they should go to, without the overload of bureaucratic challenges and be able to use all of what that one seaside could offer. They would be able to see, experience and use all the possibilities that the sea and the beach could provide. Then they really could be safer, with no added bureaucratic forms to fill in. People would be able to really be here in a mindful way, with no thoughts about another beach, lost time taken away from family and exhaustion from running from one to another. Then they could really be here and use all the opportunities of the potential and abilities they have in them, and when at home, really be at home with all their body, mind and soul.

Meanwhile the sea and seaside exist on their own. They were here before us and will be here after us, if we just would think and act in a way that will allow sustainability, not just constantly making new guidelines, rules, to provide order and endless check-up lists for appropriate behaviour around the sea and beach. It is an essential and vital part of nature, you can't just act with it as guidelines or check-up lists say, you should also understand and listen to it, constantly, as it is ever changing! And to be able to do all that you should be open minded as well as professional.

And it turns out you cannot do all that if you are exhausted and overworked.

(Self-reflection from 13.07.2024.)

Recommendations

For every profession has something about it of fate, of external necessity; it demands that one give oneself to tasks that one would not seek out as private aim.
(H. G. Gadamer, 2013, 12)

As described in findings of this Thesis, midwives noted that there is urgent need for honest self-reflection and teamwork with mutual support for every midwife in order to successfully promote such core elements of the midwife's professional identity as love for humanity and belief in God / higher power and a woman's own ability and a midwife's ability 'to go with the flow', courage and persistence, ability to draw boundaries and attain professional/private life balance, to be able to use midwifery education and lifelong learning as a tool for support and help. It is similar with cooperation and communication with representatives of any professions at work, if there are problems, they should be talked about openly otherwise nothing will change.

As in findings of this Thesis also according to literature for high quality perinatal healthcare provision, evidence-based theory and midwives' professional education should go in hand with professional judgement based on experience in practice and humanistic aspects of care (Shakibazadeh et al., 2018), (Lundgren Ingela, 2022) p. 83–86. So, the voices of midwives should be taken into account in process of decision-making for care plans and next steps in the healthcare process for mothers to be, and the mother and child. In order for those midwives' voices to be taken into account, they need to be clearly expressed and heard everywhere: in conversations with women and their families; in healthcare facility units during discussions with obstetricians; during discussions about legislative changes with community leaders and government bodies. Those '*kitchen conversations*' and discussions among midwives themselves should be carried to a wider and louder level as the midwives also acknowledged by themselves. They are knowledgeable and experienced professionals in the industry, so it is only logical that their opinions and judgements should be widely heard.

Rather than requiring midwives to attend mandatory continuing education courses in addition to their regular duties, these courses should be included in their paid working hours. Midwives should not be expected to pay for these courses.

There is an urgent need to revise salary levels for midwives across the country to stop the chain reaction in midwives' overwork, disappointment in the midwifery profession and communication issues at work. In further negotiations with stakeholders, reports must show midwives' basic salaries for full time work in one shift, for example, excluding fees for extra services like birth contracts or other additional work such as paid services performed in addition

to basic working hours. Otherwise, such data misleads you into thinking that everything is fine and openly does not reflect the data, that in reality it is a salary for two jobs.

Additionally, all the manipulations and consultations performed by midwives should be noted in billing system with NHS with their names attached, (not the doctors' names which makes them more profitable for healthcare institutions), so that the real situation can be seen in financial reports about midwives' wages and work done in the public health sector. Midwives should be able to receive a salary that enables them to work full-time in one job, performing their work to a high standard and in a safe manner, without possible endangerment for service users or harm to themselves and their families.

It is not acceptable that midwives who work in the public healthcare sector are not allowed to take more than 2 weeks of vacation in the summer period, there should be no such limits. Especially in this profession, that demands so much from a person, both physically and emotionally as this profession especially requires sufficient support therapy, rest and accumulation of strength (Cull et al., 2020; Pezaro et al., 2016).

There should be more opportunities for mutual cooperation between the different generations of midwives, allowing younger professionals to work alongside more experienced midwives. This would be a beneficial situation for both groups, enabling them to exchange professional experiences and enrich each other's professional lives. There needs to be more openness, tolerance and willingness to cooperate to each other from both sides, between the younger midwives and those who have several decades of experience, with no arrogance or negative prejudices from either side. According to findings in the literature, the transition from student midwife to qualified midwife is a stressful time (Hughes and Fraser, 2011). The initiative and real cooperation must come from each midwife herself; this is not something which can be recommended or mandated by management. There is an urgent need for open and honest dialogue about mutual communication between different generations of midwives. It is also noted in the literature that there is a tight link between professional identity formation in midwifery students and young midwives, and experience gained in communication with midwives who are already practicing (Mcluckie and Kuipers, 2024).

In order to promote the implementation of these previously described elements of midwifery professional identity in practice, prospective midwives are already given opportunities to begin implementing and improving them during the study process at RSU:

1 by conducting 2 reflections on their experience and performance in each clinical practice period under the guidance of a psychologist-midwife;

2 second-year prospective midwives have the opportunity to improve themselves in a study course designed specifically for midwives “Fundamentals of Psychosomatics and Psychotherapy for Midwives”;

3 a new study course “Communication in Evidence-Based Healthcare” has been introduced;

4 during study process in all simulations, emphasis is placed not only on technical, but also on the acquisition of non-technical skills that are so important for midwives.

According to Gadamer, everyone must have courage to make use of one’s own understanding (H. G. Gadamer, 2013, 284). One can simply start with self-reflection about one’s own professional performance and see what comes up, what could I start doing myself to promote the implementation of core elements of midwifery’s professional identity in practice?

Publications and reports on topic of the Thesis

Publications

1. Ansule, I., Fleming, V., Millere, I. (2024). "To be a midwife in Latvia – Midwives talking – Pilot study", *Heliyon* , Journal article https://doi.org/10.1016/j.heliyon.2024.e32504
2. Stenbäck, P., Ansule, I., Liepinaitienė, A., Vik, E. S., Österberg, T., Ekelin, M., Hasman, K., Furskog-Risa, C., Mortensen, B., Valgeður L. S. et al. (2023). "Empowering Nordic and Baltic midwifery students and teachers in multinational collaborating learning of research", *European Journal of Midwifery*, 24.10.2023. Journal article, Part of ISSN: 2585-2906 https://doi.org/10.18332/ejm/171986
3. Ansule, I., Ķīvīte-Urtāne, A., Millere, I. (2021). "Patients need to receive the same kind of information about the same issue from each professional", 15th International Scientific Conference, Rēzekne, 29.05.2021, Proceedings of the International Scientific Conference. Volume IV, May. 265–273, https://doi.org/10.17770/sie2021vol4.6405

Monography

1. Ansule, I. & Irša, S. (2025). "Evidence based Midwifery Knowledge and Practice" , (Contains 415 pages; the work contains 57 tables, 285 schematic drawings and scanned images of historical evidence). (Approved by Rīga Stradiņš University Science Council 20032025 No.6-ZP-1/3/2025 (No. 6-ZP-4/7/2025), accepted for publication 05.2025.)

Reports

I. Presentation and poster presentation **"Midwives, obstetricians and neonatologists view on realistic possibilities for better intranatal care quality"**, at the "Normal Birth" conference in Aahus, Denmark 12.–14. 09.2022.https://njfcongress.dk/programme/programme

II. 11–12. 04.2024. On the invitation of WHO, simulation training was conducted in Kyzylorda and speaker duties on the topic **"A practical look at the midwife's responsibilities in caring for women and newborns based on current scientific recommendations"** with simulation training sessions; 1st lnternational Congress of Midwifery Specialists of the Republic of Kazakhstan "Ayali alaqan", Astana https://nu.edu.kz/news/nu-school-of-medicine-involved-in-creating-midwifery-professionals-environment

III. 10.04.2025. Report while performing speaker duties at the II International Midwifery Conference "Who do midwives serve?" on the topic "**Communication challenges and solutions – in perspective of Latvian Midwives"**, Riga, Latvia https://vecmasuasociacija.lv/current-events/whom-do-midwives-serve/

IV. 18.04.2025. On the invitation of WHO, performance of speaker's duties and oral report on **"Methods of pain relief in childbirth and emergency care in midwife's practice based on current scientific recommendations"** at the III International Conference of "Health of the mother and child – future of Kazakhstan", Almaty

V. 26–28.05. 2025. Ansule, I., Fleming, V., Millere, I. **"Experience of reflecting on current midwifery practice"**, Poster presentation and oral presentation "Healthy birth: a cross-national student midwife project from the Baltic and Nordic countries", Eline Skirnisdottir Vik, Pernilla Stenbäck, Jana Meier, Terese Österberg, Ansule, I., Maria Ekelin, Kirsten Hasman, Eva Christina Furskog-Risa, Valgerdur Lisa Sigurdardottir, Berit Mortensen, NJF Congress 2025, Copenhagen, Denmark https://njfcongress.dk/programme/programme

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But I found the poem by which I want to express my gratitude to her:

Come to the Edge
by Christopher Logue

Come to the edge.
It's too high!
COME TO THE EDGE!
And they came,
And he pushed,
And they flew.

I want to express my sincere gratitude to each midwife for their courage so openly speak with me and express their deepest thoughts and concerns. As I know how painful sometimes those dialogues with me were for them. I am not even sure that I or them even imagined before we started that those conversations sometimes could be so revealing, but at the same time painful. This poem is for them:

Sometimes
by Sheenagah Pugh

Sometimes things do not go, after all,
from bad to worse. Some years,
Muscadel faces down frost; green thrives;
the crops do not fail;
sometimes a man aims high, and all goes well.

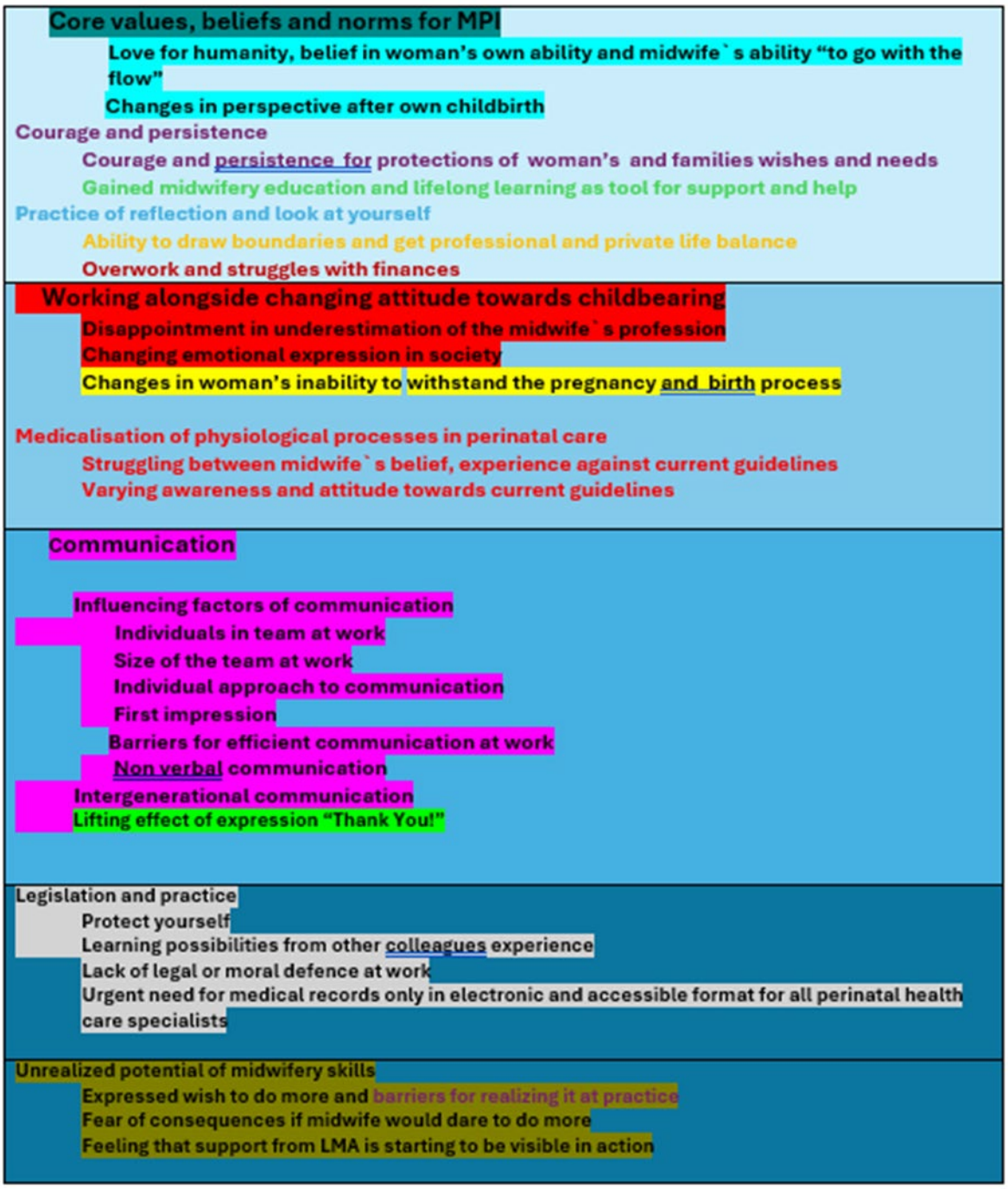
A people sometimes will step back from war;
Elect a honest man, decide they care enough, that they can't leave
some stranger poor.
Some men become what they were born for.

Sometimes our best efforts do not go amiss,
sometimes we do as we meant to.
The sun will sometimes melt a field of sorrow
that seemed hard frozen: may it happen for you.

To my close family, I want to simply say that without you
(my husband and miraculous children)
I would not be able to do any of it!
Thank you for letting me be as I am!

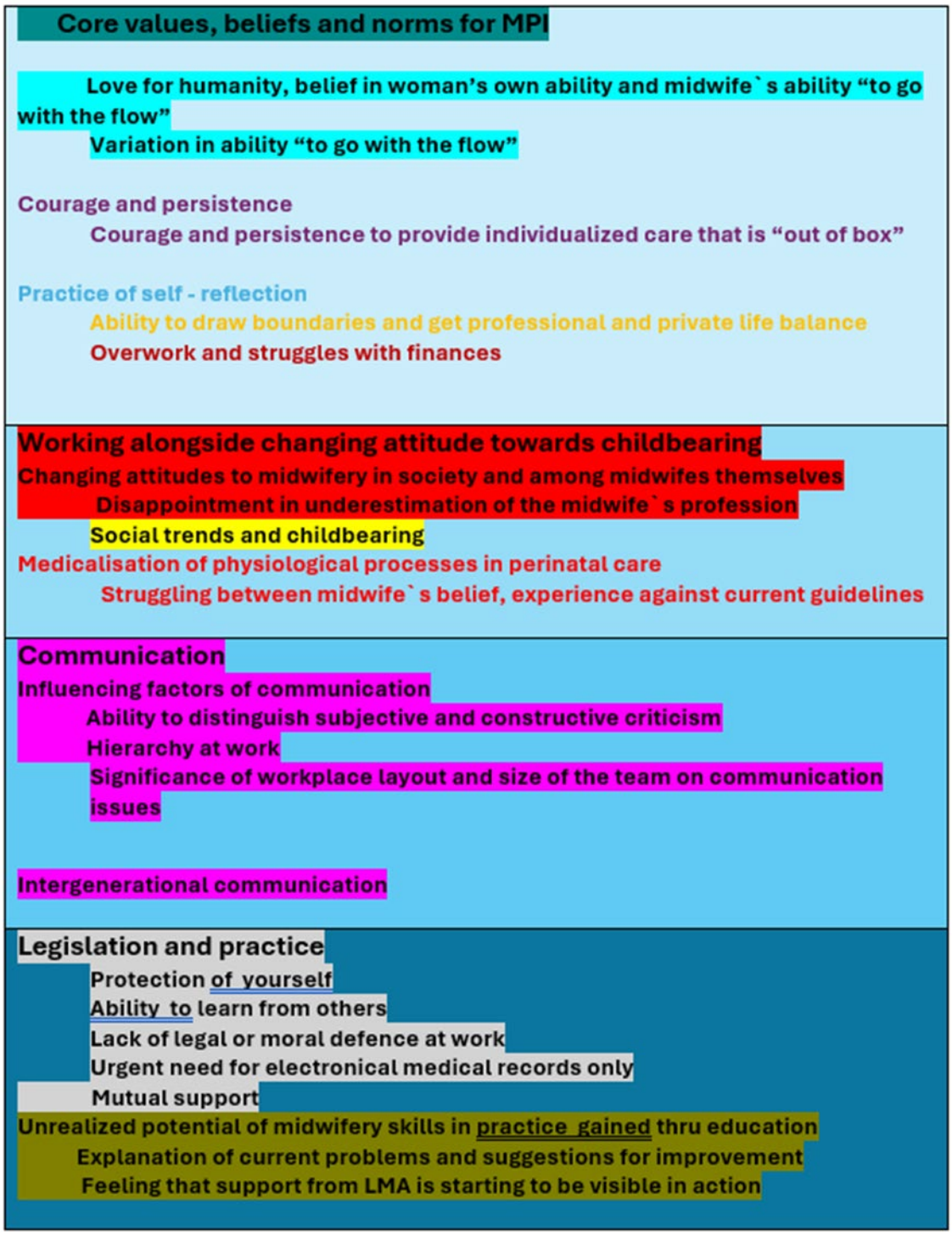
Annexes

Work sheet: Theme map after first round



Annex 2

Work sheet: Theme map after second round



Annex 3

Work sheet: Theme map after third round

Core values, beliefs and norms for MPI

Love for humanity, belief in woman's own ability and midwife's ability 'to go with the flow'

Courage and persistence needed more than ever

Professional and private life balance

Overwork, struggles with finances

Working alongside changing attitude towards childbearing

Disappointment in underestimation of the midwife's profession

Changing attitudes to midwifery in society and among midwifes themselves

Social trends and childbearing

Medicalisation of physiological processes in perinatal care

Necessity for more broadcasting in media midwives' attitude towards medicalisation of childbearing

Communication

Influencing factors of communication

Intergenerational communication

Possible solutions for improving communication

Legislation and practice

Urgent need for electronical medical records only

Unrealised potential of midwifery skills and suggestions for improvement actions from direct management, LMA and legislatives