

8-2019

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EMOTIONAL LABOR AND CARE DELIVERY:
INTERVIEWS WITH OBSTETRICAL NURSES

A Thesis

Presented in

Partial Fulfillment of the

Requirements for the Degree of

Master of the Arts

September 2019

BY

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Abstract

Using a qualitative approach, twenty long-format interviews with registered nurses with experience working in obstetrics (OB RNs) were conducted using a structured, open-ended question guide to investigate occupational culture, the impact of societal forces on work, and the role of emotion in nursing. Audio-recordings of the interviews were analyzed for themes, using grounded theory. Within the culture of OB RNs, the duty of providing safe care was embedded throughout conversations as a duty, a safety imperative. Since OB RNs saw their job in terms of safety foremost, friction arose when others held differing expectations, influenced by medical dominance and the ambiguity of the nursing role. By justifying the emotional labor routinely performed as an important nursing function, the participants did not conceptualize their emotional labor as problematic. Instead, the OB RNs reported deriving meaning from their work, described emotional aspects as fulfilling, and were bothered at the economic description of selling care on the marketplace. The main sources of frustration voiced were lack of respect, a profit-driven system, and an inability to provide the safest care within those restraints. The major implication would be to promote understanding of the substantial work of nursing specifically and care work broadly, to encourage nurses' agency and to continue to build a sociology of nursing.

Keywords: nursing, birth, emotional labor

Emotional Labor and Delivery: Interviews with Obstetrical Nurses

I have been working as a registered nurse (RN) in the field of obstetrics (OB) for over ten years. When a close friend had some serious complications giving birth, her partner asked me, “How do you do that every day? I really thought my wife might die and everything- the labor, the pain, the exhaustion, the blood, the terror- was just so intense. I don’t understand how you can deal with that.” I was surprised that I did not have an answer. I vaguely answered, “I guess you just get used to it.”

I have thought about that very question from an outsider seeing my work as an OB RN and this has driven my research. In my daily work with life and death, I wondered why I no longer noticed the depth of emotions, how intense situations transformed into routine and what role emotions played for OB RNs. The deeper issue is sociological, navigating an attempt to see my work like an outsider does, but with the understanding of an insider.

While there is an entire body of nursing literature, sociological analysis of the occupation is lacking. Nursing scholarship has certainly borrowed from social theory and applied concepts. However, the aim of this project is to examine much closer the occupation of nursing in context of the experiences of those in the field.

Obstetrical nurses work at the intersection of the medical institution and symbolic event of birth. Their labor provides a window into the realities of medicalized birth, the navigation of both complex interpersonal interactions and emotion-laden experiences within a workplace. OB nurses witness daily how the underlying power dynamics of our society shape families, work and health care.

The nursing occupation has been traditionally undervalued as women's work. By listening to the voices of nurses, their labor thus becomes valued. The arena of childbirth has become an ideological battleground for various groups, from natural birth advocates, feminist activists, global health experts and mainstream Western medical management of birth. Despite the disparate discussions around childbirth, the vast majority of women give birth in the US in a medicalized setting. Talking to the women who work on the front lines of birth in America allows for a unique perspective on negotiating this reality.

Beyond a capitalistic or purely economic-based viewpoint that focuses on work for income and market forces, I want to know how people feel about their work, what do they enjoy, and what do they dislike. I am curious what meaning they find in their work, and how it shapes the rest of their lives. I want to know what they think about external forces that impact their jobs, the trends in an industry that change over time and how the social stratification of the outside world becomes reproduced, challenged or flipped in their job environment. I wonder if an occupational group truly has its own culture and how that gets passed on, including the moral codes, superstitions and language.

Work that involves emotions comes with its own set of questions. I would like to see the various ways a full range of emotions are managed and what are some of the strategies employed. I am curious if nurses find this ability to manage emotion is innate, stemming from emotional intelligence, or see it as more of a learned behavior. I wonder how experience matters and what certain situations could be more problematic for controlling emotions.

The research questions are as follow: How do OB nurses understand their occupation and culture of work? What is the perspective of OB nurses on interpersonal relations and the power

dynamics of their work around hospitalized birth? What role does emotion play in their work? Ultimately, what can the experiences of obstetrical nurses tell us more about society?

The process of this inquiry can be likened to pulling out one tiny piece of a larger, complex machine. By examining the piece from different angles, seeing how it connects and works in conjunction with the whole, the way the machine works becomes clearer. However, figuring out how to see the complete machine from the inside of that tiny piece, while in motion, is the true challenge.

Literature review

Study of Work

The meaning of work in the context of an occupation has long been the topic of analysis. *The Sociological Eye* by Everett C. Hughes (2009) offers a multitude of insights and useful concepts to study occupations. His book of essays forms the theoretical foundation for this research study. Hughes so eloquently argues that sociology needs to study occupations to learn about our social world. He validates the ultimate purpose of this study, saying that understanding the relationships between individuals and their work says more about society as a whole. Looking at social norms, acculturation and variance within an occupational group can demonstrate some of the forces that shape our greater social world. Hughes (2009) wrote, “Almost any occupation is a good laboratory animal for some aspect of work control, organization or culture. It may disclose easily some aspect which is hidden in other cases or it may show in developed form what is incipient in others” (p. 301).

Work is a defining characteristic of human life. Even an unemployed person gets defined by their lack of work. Since people spend a huge portion of their lives at work, shouldn't that be

studied? In his essay titled “The Study of Occupations,” Hughes (2009) states, “Any occupation in which people make a living may be studied sociologically” (p. 283). Then he theorizes the most can be learned when the researcher pursues the “ulterior goal of learning more about social processes in general” (p. 283).

For Hughes, the definition of occupation is, “not at some particular set of activities; it is the part of an individual in any ongoing system of activities” (p. 286) Within the study of occupations, Hughes lays out two important concepts, license and mandate (p. 287). License refers to more than the legal authorization to perform certain duties and includes the socially agreed upon ability to cross certain boundaries. Mandate can be construed as the area of social control and behavior ingrained in the spheres of influence of the profession. Registered nurses (RNs) have the legal license by the state they practice, and social permission to do certain duties and witness certain moments that a lay person would not. The broad mandate of nursing would include the duty to provide nursing care and support patients. Implicit mandates of nursing, arguably, could include deference to doctors, self-sacrifice, and emotion management to name a few. These concepts are examined in relation to the interview respondents’ views of OB nursing.

Another concept introduced by Hughes (pp. 288-290) is the realm of guilty knowledge, which is the privileged information given access to by certain occupations. This idea contains more implications in this research than the privacy laws about health information. First, within certain occupations, the members have access to personal and potentially compromising information about others. This changes the nature of the balance of the relationship, forming the basis of a clinical perspective. This guilty knowledge, according to Hughes (2009), is a model of a different, potentially shocking way of looking at things. Every occupation must look relatively at some order of events, objects or ideas. These things must be classified, seen

in comparative light; their behavior must be analyzed and, if possible, predicted. A suitable technical language must be developed in which one may talk to his colleagues about them. (p. 289)

He is referring to a way of interpreting situations, understanding them and using the shorthand type of communication that is learned as part of the acculturation to an occupation. An analysis of the OB nurse's perspective and their common language demonstrates the concept of guilty knowledge.

The way some nurses talk about patients can seem callous, cold or cruel, but this behavior serves more than a need for "venting" or simple gossip. In Hughes' (2009) opinion, "This technical, therefore relative, attitude must be adopted toward the very people whom one serves; no profession can operate without license to talk in shocking terms behind the backs of its clients" (p. 289). Desensitization is a byproduct to the guilty knowledge afforded by an occupation's license.

In conjunction, Hughes raises a point about the relativity of time within a professional occupation that does not match the usual sense of urgency (p. 290). What constitutes an emergency for an OB nurse can be quite different than what seems to be for the patient. Conversely, a physician may take a broader view on the progress of a patient's labor that seems like stalling to the nurse. Emergencies and crucial situations do have a component of relativity, although medicine purports to be a science.

To illustrate the idea of the historical occupation, Hughes employs the example of nursing (pp. 293-294.) Nursing has existed for many years, but the occupation of nursing has changed greatly. Nurses have taken on increasingly challenging work while delegating more

menial tasks to support staff, yet physicians as a group have challenged their expanding authority, especially with the case of advanced practice nurses. The varied work of nurses today is quite a shift from the time Hughes wrote. By looking at the changes in the definition of the duties and roles, the social construction of an occupation becomes more apparent. If what a nurse does for work can drastically change over time, then perhaps the occupation of nursing is not concretely bonded to its limitations of the past.

The term “adult socialization” is used by Hughes to describe the process of becoming a member of an occupation (p.295). While this includes the technical duties of work, there is more to consider, like the ways of perceiving the system one works in and how to relate to it. For nursing, the health care system is the setting and nurse is the role. Adult socialization into an occupation can be seen within nursing.

Study of Nurse’s Work

In 2000, nursing scholar Joanne Disch made a call to action for nurses to “Make the Glue Red.” She began this short essay by quoting a physician, who remarked after being hospitalized as a patient, he had a newfound understanding of nursing as the glue that holds the organization together. This description of nursing underscores one of the core problems of the occupation. Nursing is widely misunderstood and poorly defined in the public mind. Nurses are portrayed as living angels, doctor’s helpers, bedpan cleaners, and a host of other things. Rarely is the complexity and reality of nursing understood, as also described by Suzanne Gordon in *Nursing Against the Odds* (2005).

Disch takes the metaphor of nurses as glue a step further by describing the often invisible and hidden nature of nursing work (2000). She writes that glue dries clear and becomes invisible,

despite its vital role. Nurses bring the health care directly to the actual patient and work across disciplines to provide that care. Nurses, often seamlessly, combine analytical skills with continuous assessment, perform clinical tasks, document care administered, update the treatment team, and provide emotional support within a holistic framework. When nurses do their work well, it can appear simple or even invisible to the health care system. Holding the system together is demanding work and should be recognized. Disch calls to “make the glue red” to further define nursing, to provide nurses with the appropriate collaborative status within the health care team, and to ultimately guarantee the nursing’s position among limited resources. These interviews in this project are in response to Disch’s anthem.

Suzanne Gordon has focused for years on researching the problems of the nursing profession. Her book, *Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes and Medical Hubris Undermine Nurses and Patient Care* (2005), takes a critical look at the state of nursing in the United States. Her outlook on the nursing profession were echoed by many of my interview participants. While looking at how nurses interact with medicine, the hospital system and the media, she attempts to delineate why nursing is so poorly understood and how difficult nurses find their jobs. Gordon looks at how nurses cope with the frustrating combination of dissatisfaction with the health care system and the reality of being overburdened by capitalist motives that often complicate nurses’ work (2005).

Gordon’s book reviews the history of medical dominance over nursing and addresses some of the problems in the unbalanced relationship. The nursing occupation has a complicated relationship with medicine and Gordon delves deep into those issues. Within a sociopolitical stance, she argues that nursing needs to be valued to improve health outcomes and listening to nurses will shift the power structure of the health care system.

Whilst discussing the history of medical dominance in health care, Gordon cites the linguist Deborah Tannen, saying “human interaction is a ‘joint production’” (Gordon p. 123). Just as doctors have been socialized historically to treat nurses with indifference- at best, and disrespect- at worst, nurses have conversely been socialized to treat doctors with respect and deference. This social hierarchy perpetuates itself through interactions and training (Gordon 2005). This concept is further explored in the research by Davina Allen.

Examining the relationship between doctors and nurses goes beyond the previous research on medical dominance. Davina Allen observed and interviewed doctors and nurses in a UK hospital, looking carefully at their interactions for “negotiated order,” a term coined by Strauss to define the constant interplay of social structure and ongoing negotiations by social actors to interact within the construct (Allen 1997). By applying the concept of negotiated order to nurses and doctors, she found little conflict in shifting responsibilities to nurses and postulates that “non-negotiated boundary-blurring is a taken-for-granted feature of normal nursing practice” (Allen p. 506). Allen found nurses do not see the lines between medicine and nursing as starkly divided, that they “were often more knowledgeable than doctors about the ward specialty. Nurses exerted an importance influence over treatment decisions” (p. 506). By breaking formal policies and bending rules, nurses often did the work of doctors, like ordering medications or labs, in order to decrease the burden on the doctor and expedite patient care. Allen found negotiated order as a concept did not quite appropriately describe what was observed and she looks for a broader definition of social order beyond negotiation.

Suzanne Gordon refers to the way nurses manage to affect decision-making as “the art of indirect manipulation-polite wheedling, nudging, needling and persuasion” (2005 p. 294). She stresses this tactic is unsurprising in a system of inequality, as is seen in other subordinate

groups, but is especially rooted in nursing practice. Nurses are expected to calm patients and maintain order, which is linked to what Gordon calls manipulation and conflict avoidance. Framing questions and concerns in a nonconfrontational manner is part of therapeutic communication, a tenant of nursing practice. The essential problem, according to Gordon, in the medically dominant health care system is “nurses get the responsibility without the authority” (p. 72).

Is nursing a profession? This long-standing theoretical debate over definitions may be missing the mark. Understanding the character of the work of the nursing occupation can be a far more interesting question. A sociological analysis of the meaning of definition of nursing as a profession or a semi-profession particularly emphasizes the point of the fluidity of definition of profession. Authors critique the past sociological discourse on professions as inadequate (Ayala, Vanderstaeten & Bracke 2014). According to this review, historical approaches take an evolutionary and narrow view, structural perspectives take on an “ideal type” that has become diluted by institutionalization, and the functional perspective false legitimizes the disparities within the workforce. The systemic approach to studying professions offers a more pluristic view. For nursing, the systemic analysis is fluid, considering the work within a global and contextual framework, that is constantly negotiated and changing. This is conceptualized as an ecology of nursing, taking into account a larger organism-like view, with forces like bureaucracy, hierarchy, institutions, and gendered work. Nursing as an occupation may differ across discipline, time, culture, country and institution (Ayala et al 2014.). The similarity of setting for the OB RNs in the US interviewed can allow a closer examination of their experience in context. The authors call to action to build a sociology of nursing, to grow the comparative

body of work within the ecologic theory (Ayala et al 2014). This project responds to that call and to look beyond professionalism for nursing.

In an article in *Nursing Economics*, over 800 Texas RNs were surveyed about their jobs, examining quantitative data and also analyzing response to an open-ended question (Reinbeck & Furino 2005). Overall, the picture matches up with Suzanne Gordon's depiction of the occupation in "Nursing Against the Odds" and her other works. While these RNs reported "intrinsic rewards" of nursing, they also reported exhaustion and frustration, particularly with increasing amount of patient care workloads (Reinbeck & Furino 2005). Concerns with staffing levels and the resultant decrease in quality care were among the major themes. Of those surveyed, 75% of nurses reports general satisfaction and 72% reported exhaustion. So, while nurses report to like their jobs, they also report being overly tired.

The consequence of overburdened nurses in the OB field was examined by Simpson and Lydon in several focus groups, including a total of seventy-one OB RNs (2017). Labor and delivery nurses discussed what happens when there are too many women in labor and not enough people to provide nursing care. Nurses in the study reported maintaining clinical, technical care of their patients as best as possible, while allowing the supportive and emotional aspects of typical work to be less prioritized. Despite seeing technical aspects of care as unquestionably necessary, the participants reported an increased likelihood of negative birth outcomes when nursing resources were inadequate. According to the participants, the supportive and emotional aspects of nursing care were also seen as essential to safety and positive birth outcomes but were less likely to be performed with inadequate staffing. This research supports Suzanne Gordon's arguments about the problems of nursing, while focusing specifically on the world of OB.

Over three thousand nurses in the US in ten hospitals across 110 units were surveyed about their jobs, staffing levels, and about uncompleted tasks and care (Kalisch & Lee 2011). This research study further confirms Suzanne Gordon's portrait of the problems of the nursing occupation within the current healthcare system. While these trends may seem intuitive, the findings are significant nonetheless. Nurses who report having enough time to complete their work report being more satisfied with their specific jobs and their occupation overall. (Kalisch & Lee 2011). The perception of adequacy of staffing and resources was significantly predictive of a higher job and occupational satisfaction. There was no correlation between satisfaction and various factors like age, gender, number of hours worked, overtime, experience or shift. The authors point to the underlying motivation of a service-oriented occupation like nursing and also a noticeable positive effect of providing care that underscores this relationship (Kalisch & Lee 2011). While the authors do not discuss the cause of the missed nursing care, the likely culprit is the constraints of a profit-driven health care delivery system.

"Hurting at work: the lived experiences of older nurses" is qualitative research that takes a close look at the difficulties experienced by older nurses suffering with pain and depression (Letvak 2009). The toll of decades of physical and emotional labor is described in detail by the author and her participants. The physicality of nursing work is highlighted with an exploration of how aging impacts ability to perform nursing care. A call for organizational support and a reminder to remember the positive impact of nursing on patients are the proposed solutions (Letvak 2009). The overall working conditions of nurses, including increasing patient acuity and heavier workload assignments, is not directly challenged. This focus for nurses to support each other and lean into altruistic motivation is typical of Gordon's critique of the saccharine self-perpetuating selfless doctrine of nursing.

Horizontal bullying consists of peer-to-peer intimidation practices, and this behavior is found in nursing. Researchers cite studies claiming 65-80 % of nurses reported witnessing this widespread issue, and more than half reported being the target (Granstra 2015). The power structure within hospital culture may be to blame, because, “Bullying is especially associated with workplaces that are hierarchical” (p. 252). Other possible factors are a sense of protectiveness of patients, seniority, insecurity, and territorial actions. With the prevalence of the problem in nursing, the causes should be examined in a systemically rather than exclusively on individuals (Granstra 2015). The key notion here is that nurses tend to bully each other, thus creating a hostile work environment.

The role of workplace bullying in nursing is examined through a historical lens (Lim & Bernstein 2014). Records show that the quintessential founder of the nursing profession, Florence Nightingale, was known to be demanding and embody the traits of a workplace bully. Within a caring occupation conceptualized by its altruism, there is paradoxically an elevated level of workplace bullying in nursing, with prevalence rates ranging from 21% to 70% (Lim & Bernstein 2014). There is a well-known adage that “nurses eat their young.” Does this ring true for obstetrical nurses today?

For nurses, “staffing” is a catch-all term that describes the dynamic process of assigning patient workload to nurses and includes factors like patient acuity, assignments, floating, on-call and ratios. Staffing is determined by the number of nurses on the schedule and the number and types of current patients. Discussion around nurse staffing can be framed by both nurse/patient ratios and increasingly complex care and co-morbidity of diseases, which leads to a higher acuity. The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) is the professional organization leading the field in evaluation of staffing in OB. AWHONN does not

recommend a mandatory nurse to patient ratio, but rather recommends a multifactor approach that considers nurse, patient and system factors specific to obstetrical nursing (Bingham & Ruhl 2015). A call for more research into how staffing impacts nurse satisfaction and patient outcomes may be shadowed by cost control measures (Bingham & Ruhl 2015). Understanding how nurses in the field see the issue of staffing is a topic of discussion among OB RNs in the research interviews.

Nurse turnover can be problematic. Training new nurses is expensive and lack of clinical expertise can be detrimental to patients. 27% of new graduate RNs leave their first nursing job within a year (Christmas 2008). By identifying pertinent issues to nurses, possible solutions can be explored to increase retention. According to Christmas (2008), the entire nursing workplace environment must be examined to address issues like inadequate staffing, underdeveloped nurse training programs, excessive charting requirements, lack of resources and equipment, poor physical design layout, and increasing patient acuity. To fix retention, the problems of the nursing profession must be examined. This article mirrors back to Suzanne Gordon's critiques of nursing and also is reflected in interviews with OB nurses.

Within a global context, the occupational role of the nurse may differ, although there may be some similarities. A brief comparison of how nurses report on their work across cultures may offer further background information. Kumar (2014) authored a quantitative study looked at the occupational stress and job satisfaction among nurses in India. Using previously validated tools, eighty nurses were surveyed about stress and satisfaction, in conjunction with additional factors. Nurses reported no significant difference in work-related stress, whether they worked in private or public hospital, rural or city areas, or education level. Their jobs were equally stressful. However, nurses with higher education were more satisfied, as were nurses working in private

Indian hospitals. Kumar's analysis showed high levels of stress in Indian nurses and varying levels of job satisfaction, mediated by education and setting (2014).

Despite the rhetoric of the nursing occupation in crisis, another study found that nurses were among the least likely groups to be in poor health (Shockey et al 2017). Nurses were also on the lower end of the spectrum of occupations that reported recurrent psychological concerns, physical concerns, and activity restrictions. However, nurses' aides, deemed "health care support," reported more problems, especially on activity limitations. Researchers hypothesize that nurses' aides engage in more physical labor and their bodies show the resultant deterioration (Shockey et al 2017 p. 1320). This finding outlines the issues of nursing, typified by Gordon's call to action, in a larger perspective and highlights the need to look at the hierarchy within healthcare, beyond medical dominance. Inequalities may yield further inequality, through self-reproduction across hierarchies.

Consumer-driven culture has begun a shift in healthcare, to see customers instead of patients. This is part of a larger discussion whether health care is a business, a service, an institution, or otherwise defined. Nursing has been impacted in this push for a consumer model of healthcare and patient satisfaction measurement. A 2013 study surveyed 159 nurses in Australia to look at the intersection of emotional labor, job satisfaction and customer orientation (Gountas, S., Gountas, J., Soutar, & Mavondo). Unfortunately, the researchers used the word "customer" as a substitute for the word "patient," incorrectly assuming nurses would see the meanings as the same. The commercialization of healthcare may not necessarily be perceived as a positive trend in the minds of nurses. This issue was further raised in the interview questions with OB RNs.

Despite the assumptions of RN's consumer-focus of Gountas et al, there were additional insights from their research (2013). Understanding how nurses see their work in Australia, beyond a US setting, provides an opportunity for comparison. Nurses reported, on average, to have job satisfaction, express empathy, and to have a customer (patient) orientation. Surprisingly, nurses surveyed did not report emotional exhaustion, or to engage in emotional labor. However, with the lack of clarification in language with the patient/customer, it is suspect that the questions about emotional labor could have been ambiguous. The authors themselves point to a possible respondent bias around concerns of "inauthenticity" shaping concepts of emotional labor (Gountas et al p.1560), with a call for further research.

Researchers have attempted to measure job satisfaction and now there is a growing body of literature on what can make work enjoyable. The concept of "flow" as a psychological state was popularized by Mihaly Csikszentmihalyi that is characterized by total engagement and engrossment in a task, leading to a suspended sense of time (1990). Studies of flow in the workplace have been expanding, including the nursing occupation.

In 2011, a study of nurses and nurses' assistants in Sweden looked for flow-like states and found direct medical care activities and situations requiring critical thinking (Zito 2016). Overall, nurse assistants were less like to report flow situations, perhaps because nurses were more likely to provide medical care. In a different study of Italian nurses, the availability of resources was key to promoting flow and also decreasing exhaustion (Zito 2016). This finding relates back to Suzanne Gordon's argument that the problem of nursing lies in the lack of power and resources.

A Cochrane Review published in the journal *Evidence Based Nursing* in 2002 found that having constant support for a woman giving birth is related to better outcomes, both in medical

factors and in reported patient satisfaction (Hodnett 2012). Unfortunately, the review did not differentiate between professional support like nurses and lay support like partners or family members. When giving birth, women and their babies clearly do better with help, but the constraints of modernized hospital care do not allow for nurses to be at the bedside providing continuous support. OB nurses frequently are responsible for caring for several patients at once and have a workload of tasks, like documentation and paperwork. This tension between the perceived role of the nurse as emotional support versus the complete reality of the job expectations of the nurse can lead to frustration from the patient and also the nurse. The perspective of the OB nurse on what the priorities are may differ a great deal from the patient. The question of whether or not OB nurses actually want to provide continuous labor support is a different matter altogether—they simply cannot because of their basic job requirements. The lack of role clarity can be a source of ongoing tension, particularly when research shows how important continuous labor support is for maternal-child health outcomes (Hodnett 2012).

Medicalization and Birth

Peter Conrad's *Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (2007) offers a useful theoretical framework for examining the state of current birthing practices in the United States. Although his work does not focus entirely on birth or nursing, he presents a strong case for the underlying social construction of disease and resulting medical practice. By “bracketing” the discussion of the authenticity of medical conditions like ADHD and male menopause, he effectively sidesteps that controversial line of discussion. Instead, he turns attention to the underlying expansion of the medical model, highlighting how it is connected to the pharmaceutical industry. The point is not whether or not social anxiety disorder actually affects millions of Americans, but rather that a successful

marketing campaign by a multinational drug company led to a new diagnosed chunk of our population with a previously uncommon diagnosis. The expansion of medical authority over social issues includes pregnancy and childbirth.

Conrad (2007) touches on the medicalization of childbirth in the US at several points, but instead chooses to focus on the expansion of medicalization to men's issues, like erectile dysfunction and baldness. He does describe the height of American medicalized birth as the 1950s era, with a subsequent backlash of the natural birth movement. The current state is described as a "bifurcation" of birth practices with an elective cesarean section as the ultimate medical birth and an un-medicated homebirth at the de-medicalized extreme (pp.157-158). However, this analysis fails to appropriately address the typical birthing experience, which is more towards the medicalized side. Conrad's medicalization concept can be further applied to childbirth, particularly the literature of the midwifery and natural birth advocates.

His analytical technique of "bracketing" is useful when discussing medicalization of childbirth (Conrad 2007). Often, discussion of childbirth practices become entrapped in natural versus medical moral debate, when there is far more to examine from a sociological perspective. OB nurses are situated to offer insights into the lived reality of the tensions of a medicalized birth. Conrad's bracketing technique applied to OB nursing allows for an academic precedent to sidestep the politicized issues of birth.

Often, rhetoric and divisive discourse surrounding birth often focuses solely on industrialized, resource-laden societies. However, if the focus is pulled back to a larger scale, it becomes clear that the issue of medicalized birth occurs in context. In *The Lancet*, the medicalization and interventionist, technological management of birth was succinctly placed into a global context by use of acronyms. The Western medicalized birth model, with the extreme

example as “too much, too soon” (TMTS), was compared to the other end of the spectrum of “too little, too late” (TLTL). The article calls to find a middle ground globally, following evidence-based guidelines that are not overly reliant on expensive technology but that also ensure access to quality care and life-saving interventions (Miller et al 2016).

The elective cesarean section, without clinical indication, stands as the epitome of the medicalized birth, TMTS (Miller et al 2016). The mother may opt out of attempting vaginal birth and request a planned surgical birth. ACOG supports this practice, purportedly respecting patient autonomy. This bypasses the vaginal birth process entirely, which is problematic for the proponents of natural childbirth, despite the expressed support of women’s choices about their bodies. From a feminist standpoint, the pregnant patient is principally incapable of informed consent because the medicalization of birth has infiltrated the dominant thinking, focusing on risk and efficiency (Bergeron 2007 p. 481). Without shifting the focus of birth from a medical event to be managed to a natural process, the argument is pregnant woman may not be able to comprehend the true nature of a surgical birth, thus making informed consent impossible.

While the focus of Bergeron’s article is elective c-section, she does an excellent job of comparing the medical model of childbirth to the natural model of childbirth, highlighting some of the underlying tensions from a feminist perspective. She argues the dominant, masculine view of childbirth as mechanical does not account for the feminine approach to the childbirth as a wholistic process. The following excerpt further defines the assertion, “I claim that this interplay has led the medical profession to pursue efficiency in obstetrics in ways that deny the social and psychological impact of childbirth on women’s experience of their femininity”

(p. 481). Efficiency wins against true autonomy, in Bergeron's eyes. However, she neglects the significant role of risk in pregnancy. Risk can be understood as the conceptual underpinning of the medical model of childbirth.

The triumph of the medicalized birth as the norm in the US over natural birth is clear. In "Risky Business: Framing Childbirth in Hospital Settings," Bernice Hausman looks directly to the concept of risk to answer her question, "why are feminist views seemingly so out of touch with ordinary American mothers' experiences of childbirth?" (2005 p. 35) She argues that not understanding the role of risk in the medicalized birth is the very reason why it prevails. To illustrate this point, she takes on the ubiquitous practice of continuous electronic fetal monitoring (CEFM), which has not been shown overall to improve birth outcomes but has played a role in the increased rate of surgical births and greatly restricted women's movement during labor. Sitting in on a physician lecture about CEFM, Hausman witnesses a presentation about its problematic nature, finding "the medical evidence against continuous electronic fetal monitoring in labor did not constitute an effective argument against using it for two nonmedical reasons- maternal choice and legal risk" (30).

Compliance of women in labor is largely voluntary when potential risks of natural birth practices are framed as possibly harmful to the unborn baby, although the physician may be more influenced by legal risks. Women no longer must be tied down during delivery like in the midcentury- they now ask for monitors to be strapped onto their pregnant bellies. This is reminiscent of Foucault's medical gaze, and how we have turned it onto ourselves and the role of surveillance. If the medicalization of birth is not questioned by most of society, as Hausman argues (2005), where do nurses fit and what are the ways they feel about their role? Hausman sees risk as the driving force that defines pregnancy, with a continuum of low-risk to high-risk,

(not healthy to sick) and calls for a reframing of risk in obstetrics beyond using potential fetal harm to oppress women. Can OB nurses be seen as unwitting enforcers of the oppression of laboring women to the medicalized birth, fooled by the potential of risk?

Understanding the core differences in the midwifery model in contrast to the medical model can be illustrated by a simple prop. Midwives approach birth from a naturalist perspective, thinking of women as similar to animals in their need for a safe space for birth. The concept of privacy and respect for the birthing process are central. An article in *Midwifery Matters* tells the story of a midwife, if her patients required transfer to the hospital, that would give her patients a doorstep to maintain control over her birthing environment (Wagner 2014). This prop would set the stage for maintaining privacy, control and autonomy. Typically, hospital doors lack locks and often in OB, knocking is not the norm. It is commonplace for a woman giving birth in a teaching hospital to have multiple students, residents, and various support staff, all unknown to the patient, in the room.

Peter Conrad's concept of medicalization has been used to deconstruct the common American hospitalized birth. One of the most prominent voices in this discussion is Barbara Katz Rothman. Her work has been expounded on by many feminist writers and embraced by many in the midwifery community. In *Laboring On: Birth in Transition in the United States* (2007), her ideas contrasting the two models of birth in America are reconsidered within a more current framework, with the help of new research and supporting authors. The first and more common model is the typical medicalized delivery with an obstetrician in a hospital. In opposition stands against the second model, the midwifery model, with birth as a healthy, empowering experience attended by a midwife and a doula in the home. These extremes are not presented like

TMTS/TLTL in a global understanding of resources and cultural medical practice, but rather as ideal types in approaches to childbirth.

Commonly used language can be analyzed to further examine values. In medical discourse, the baby is delivered. In midwifery, the parlance is different, with the woman giving birth. In a brief article, midwifery advocates campaign for a shift in language. The analogy to fast food is made, extorting that pizzas are delivered, not babies (Hunter 2006). Katz-Rothman argues this same point, that modern obstetrics has the doctor delivering a baby, while midwives see a woman giving birth, presenting her child to the world (1996). The terminology reflects a difference in viewpoints and reflects the dominant actor in the scenario.

Barbara Katz Rothman presented her ideas on risk and childbirth, and aptly describes the ways birth has become medicalized. For example, a woman is not considered officially pregnant until she has been tested by a doctor, which Katz Rothman calls the “internalized medical gaze.” Obstetricians are increasingly female, so the medical control is in the name of science, not men, for Rothman. Just like Hausman, Rothman calls for a reframing of risk as in childbirth, beyond fetal risk, to include emotional, developmental, psychological risks to women having medicalized birth, asking for a way to allow for a balancing of risks (2014).

Rothman, Hausman, Bergeron and their framework misses a key point. Most proponents of the medical model of birth do truly see pregnancy as risky. After seeing the worst-case scenario one time affect one patient, it is difficult to ignore that risk for every other patient, despite the unlikeliness of reoccurrence. The unpredictability of labor and delivery can be mitigated by risk factors, but there is an element of randomness that can be terrifying to those charged with caring for pregnant women.

In a mixed methods study, Labor and Delivery nurses were surveyed about their levels of secondary traumatic stress, and compassion fatigue (Beck, C.T and Gable, R. K. 2012).

Secondary traumatic stress is defined as the occurrence of symptoms of post-traumatic stress disorder (PTSD) like heightened arousal, avoidance, and intrusive thoughts related to exposure to a traumatic event by another individual (p. 748). Using a validated screening tool for secondary traumatic stress syndrome, 63% of survey OB nurses showed secondary traumatic stress related to caring for patients during traumatic births. 35% scored at a level indicating symptoms in the moderate to severe range. The survey also asked Labor and delivery nurses to describe their experience of a traumatic birth. From these responses, six themes were identified. The first was certain situations tended to magnify the intensity of a traumatic birth, including being a novice nurse, abusive deliveries, patients with a language barrier and adolescent patients. Other themes included struggling to remain professional, agonizing what should have been, mitigating the aftermath, haunted by symptoms of secondary traumatic stress syndrome, and considering career changes. The authors call for protection against nurses from secondary traumatic stress and to create support systems for them.

This research study delineates something OB nurses probably already know. Traumatic deliveries make an impact on the nurse. Although the patient is experiencing the trauma, the nurse typically has a sense of duty to act, to care and to protect. These traumatic births can haunt a nurse and raise many questions. As witnesses to horrible outcomes and terrifying situations of life and death, the feeling of powerlessness to prevent or mitigate these situations takes an emotional toll. This is the weight of emotional labor that nurses live with. This question is addressed in the research questions of this project.

In the article, *Culture, silence and voice: The implications for patient safety in the operating theatre*, the authors discuss the theoretical application of the “safety culture,” applying strategies from the industrial and aviation arena to the hospital, particularly during surgeries. The traditional hierarchy of the medical model is not outright condemned or even directly addressed as a barrier to improved patient outcomes, which is not entirely surprising as this article was published in a journal with likely intended target of surgeons. However, the stance adopted by the authors is that silence is not necessarily passive, but “may be an active process and used defensively and strategically” (Jones & Durbridge 2016, 283). In the name of safety, there is a call for effective communications and team behavior.

Often, in Katz Rothman’s “midwifery model” of birth, the promise of safety and myth of risk is precisely what keeps women subordinate to medical, surgeons are discussing how a team-based approach that values management (2007). However, in Jones and Durbridge’s article, the relationship between medical dominance, nursing and safety is portrayed differently. The goal of safety in healthcare requires nurses’ inputs and therefore seeks to change the dominate culture of medicine. This raises the question of the relativity of the meaning of safety in health care. For Katz’ model, safety is the false promise of the scare tactic of the medical model of childbirth, but for Jones and Durbridge, safety is a “sacred” concept employed to justify a culture shift beyond medical dominance. Acknowledging that remaining silent is not always ignorance or deference is progressive thinking in medicine, and this has implications for the world of nursing.

Robbie Davis-Floyd has written extensively about birth in the US as a cultural anthropologist. In 1994, she wrote about “Rituals of American hospital birth, “after interviewing one hundred women about their birth experiences. Exploring the commonality among birth in the US, she finds symbolism in the rituals and practices of birth, permeated with technology. The

symbolism acts as metaphors for larger trends in society. According to Davis-Floyd, birth as a rite of passage is comprised of rituals, as women transition into motherhood (p. 3). Symbols take on greater meaning, the wheelchair and the hospital bed signify becoming a patient and illness, while IV fluids are representing an umbilical cord of dependence to the hospital as an institution. By likening the pregnant body to a machine, the parallel between the factory and mass production emerges. With this metaphor, doctors and nurses are skilled technicians, and the baby is new product, the postpartum woman is a by-product.

The allegory to a factory continues, with repetitive messages, like submission to the domination of the institution and the possible malfunction of the birthing body machine. While some of the rituals described have since fallen out of practice, like standard shaving of pubic hair or routine episiotomy, many described remain, like continuous intravenous fluids, continuous electronic fetal monitoring, and recurrent cervical exams. Also, she foists a patriarchal bent onto the mostly male doctors, which dates her work, as the OB field has increasingly been female-dominated. Despite this trend, a patriarchy is not imposed solely by men, as women can be part of the social construction. Ultimately, she argues that the rituals of typical American birth reinforce and replicate the ideals of American society, valuing technology, control and bureaucracy.

Robbie Davis-Floyd's article "The technocratic body: American childbirth as a cultural expression" takes several ideas about the role of technology and control and applies them to birth (1994). First, she explains the "one-two punch," as described by Peter C. Reynolds, that is the key to her understanding of ritualized, medicalized birth. By devastating a biological process occurrence with technology, like moving birth from the hands of midwives in homes into the domain of doctors in hospitals, the resulting problems are then addressed with further

technology, the second part of the “one-two punch., a cycle of mutilation and prosthesis” (p. 4). Floyd-Davis once again points out the “baby-as-product” mentality of technocracy.

After conducting forty interviews with women regarding their birth, she divided them into two groups, “homebirthers” who rejected the medical model versus professional women who embraced the technology of the medical model. Remarkably, the agency of the both groups was respected, with varying definitions of control of their bodies. The homebirthers espoused a sense of knowing and intuition, a belief in the safety of birth. In contrast, the medical model adherents felt less connected to their pregnant bodies and accepted medical authority, along with technology, to gain a sense of control and management, particularly of pain. Taking a cultural relativist standpoint as an anthropologist, Davis-Floyd does not argue that women who subscribe to the medical model of childbirth are under the illusion of social control. She maintains that their sense of power over birth through technology represents their experience. Despite honoring the perspective of her participants, Floyd-Davis still decries the system that creates this reliance on what she calls the technocratic birth.

The use of ritual in the medical institutions calls to mind the work of Michael Foucault. He coined the term “the medical gaze” and his ideas about the role of surveillance in social control are both applicable to the research, particularly in conjunction with the work of Robbie Floyd-Davis.

Nursing within Social Context

The occupation of nursing is impacted by the overall labor market and economic trends. In the US, the Bureau of Labor Statistics released a report on the economic aspect of nursing over a decade (Doflman, et al 2017). Despite a recession, and job market fluctuations, nursing

job growth was at 16% in 2014 in comparison to the 6.5 percent in all jobs. In 2015, RNs were 2% of the workforce in the US with incremental increases (p. 3). Wages in nursing have continued to grow steadily over time, with the 2015 mean RN hourly wage of \$35.42 per hour contrasted with the overall mean wage of \$23.23/hour (p. 6). RN economic trends in the Chicago area were similar to the national numbers. Overall, the economic picture for nurses looks positive, with steady job growth and steady wage growth. Do RNs see their work in these labor market terms? This project tries to answer if lived experiences of nurses reflect the economic trends from the US government.

The role of socialization and pain has been addressed in Mark Zbrowski's classic piece entitled, "The Cultural Responses to Pain" (1952). Looking at four different ethnic groups, he attempts to explain how the experience of pain is mediated through a cultural lens. Although this study may be dated, it reflects the attitude of health care workers on the front lines dealing with patients. Zbrowski interviewed a little over a hundred people to understand their pain responses in relation to their ethnic group. He also discussed with healthcare employees their opinions on the cultural response to pain. He found that Jewish patients were perceived to be vocal, emotional and anxious regarding their pain and less likely to trust medical treatment. While Italian patients were expected to be more likely emotional and vocal regarding their pain, they seemed to trust the ability of medicine to relieve their pain. The "Old American" Anglo group often described their pain in a disconnected manner, searching for accurate diagnosis and shying away from showing their discomfort. The study found Irish patients were more stoic in their expressions of pain.

This article may reflect some of the stereotyping of era and the dominant medical attitudes of the time. However, this piece offers a touchstone for examining the attitudes of OB

nurses dealing with their patients' pain. Zbrowski focused pain in ethnic groups in the 1950 in men, but his work can inform the understanding of the differences of pain experiences and expressions today. A laboring woman may have a culturally influenced expectation of what giving birth should be like. OB nurses interact with patients across cultural groups and may have observations regarding the cultural responses of pain in laboring women across various ethnic groups.

Instead of looking at how nurses see patients, a qualitative study looked at how pregnant women of Mexican origin perceived their health care providers. This research looks beyond simplistic racialized assumptions and flips the question. In an article in JOGNN, researchers Baxley and Ibitayo interviewed thirteen Mexican women in Texas about their interactions with workers in maternity health care (2015). By asking the patients about their perceptions and interactions, the cultural expectations around pregnancy care within an ethnic group were examined in a less speculative manner that allowed for women to speak to their own lived experiences. Just as the voices of OB nurses are valuable, the voices of patients deserve equitable consideration. In the interviews, there were several themes around trust and communication. The participants stated they wanted to be treated with kindness, friendliness and caring attitude. Additionally, direct clear communication was desired, particularly in their native language. Understanding the importance of the role of faith within their culture was also mentioned. The authors acknowledge the possibility of limited application across geographic areas and different countries of origin. However, the perceptions of these patients are important in informing the other side of the nurse/patient relationship in obstetrical health care.

A different way of examining the nurse/patient relationship is statistically and outcome-based. Particularly in conjunction with quality metrics and standards set by the insurance

industry, hospitals in general and obstetrical services watch certain numbers and trends, often made simpler by the electronic medical record. To decrease the cesarean section rate, there has been a push to prevent unnecessary cesarean sections for first-time mothers. The acronym NTSV rate refers to the rate of infants delivered via cesarean for nulliparous, term, singleton, vertex presentation pregnancies. Ideally, this number would be quite low and serves as an indicator for the particular hospital's evidence based practice in comparison to national trends. In a commentary in *Birth*, the authors call for holding nurses accountable for their individual NTSV rates (Edmonds Et. Al. 2016). If nursing care truly impacts the delivery outcome, as much research suggests, then theoretically nurses can be measured alongside physicians to be held accountable for unnecessary surgeries. This interesting proposition identifies a core tension in the hospital hierarchy of power and decision-making. Nurses know their work matters for the outcomes of patients, yet the accountability largely falls on the providers, who are the ultimate decision-makers. The authors acknowledge the problematic issues underlying these types of analysis, but ultimately maintain the opportunity of nurses to influence quality of maternity care should be considered.

However, in another article, L&D nurses shared strategies used to influence the outcome of a birth, despite their lack of power in the hierarchy (Simpson and Lydon 2017). With a collective goal of the vaginal birth, the OB nurse used several tactics to achieve this goal and to lessen risk of cesarean birth. They reported supporting the laboring women through the birthing process, acting as patient advocates and managing interactions with physicians. Providing emotional support and anticipatory guidance are social-emotional tactics OB RNs use to keep their patients involved in the birthing process, to "keep them on board." Acting as a patient advocate and managing interactions with physicians are related tactics. In the advocacy role, the

nurse directly offers suggestions or raises concerns with the patient or MD as potentially problematic situations arise. However, the nurses did discuss their way of intentionally misleading or withholding information from physicians, often to allow their patients more time to labor. According to the study, the perception of nurses is that doctors are often impatient and did not prioritize vaginal birth, so the “nurse lies” were a justifiable strategy (86). These types of interactions are further explored in the research questions of this project.

Comparing these two articles uncovers an underlying tension. Nurses may influence birth experiences and outcomes, but they ultimately lack the ability to make the decisions. This internalized sense of responsibility for positive birth outcomes and general commitment to vaginal birth leads nurses to find ways around their lack of formal power in the hierarchy in the hospital.

Care Work

Providing care as part of paid labor is examined by Rachel Dwyer (2013), in the context of the changing economy. She does a masterful job of summarizing the research and theory around the social factors contributing to the changes in the American economy in the last thirty years. By examining increase in the numbers of high and low wage jobs and the decline of middle-income jobs, she points to the growth of jobs in the caring profession as the missing key to the ongoing discussion. Through statistical analysis, the data from the Bureau of Labor Statistics from 1983-2003 reveal a pattern of increasing jobs for white women in the top paying care jobs, like nursing and education, while there is a corresponding growth of lowest wage jobs for minority women. Drawing from the theories of Mignon Duffy, care work is divided into two types, nurturant and reproductive. Reproductive care work can be explained in a Marxist framework of the more physically-oriented labor like cooking and cleaning. In contrast, nurturant

care work is defined as “direct labor to enhance the health, well-being or development of other people” (Dwyer 2013). Reproductive care work continues to be devalued because it is traditional women’s work, conceived as inherently female without skill. Comparing the market value of these types of work quantifies the way our society collectively differentiates their respective worth. Looking closer at the changing trends in the growth of jobs and comparative pay across these 2 types of labor shows an even clearer picture of the stratification of the world of care work, showing the lower paid and “less skilled” jobs disproportionately belong to women from disadvantaged groups.

Dwyer’s study offers a useful framework to understand the role of nurses in today’s economy, particularly in the interconnected inequalities of race, gender and class. Nurses’ quest for professionalism has not occurred in isolation. In attempts to establish itself as a profession, nursing has become separated from other jobs in the care work field, focusing on the nurturant aspect over the reproductive. This effectively leaves the “dirty work” of nursing to nursing assistants and further divides women across color and class lines. If this economic trend persists, there are further implications for the relationships among care workers. To understand the nature of nursing, these underlying trends and tensions must be recognized. In the interview guide, participants were asked to discuss the relationships within the hospital hierarchy and to discuss discrimination on the job.

Bullock and Waugh discussed some of the issues of the inter-professional power dynamics in their study of women working in the long-term care field (2004) They held focus groups with nurses, licensed vocational nurses and certified nursing assistants, discussing the issues of performed caring as work and at home. Most their participants described a struggle with balancing these two worlds. However, there were distinctions across the status groups. RNs are

at the higher end of the caring professional ladder with white women over-represented in the higher income brackets. In 2000, 90% of RNs were white (2004). Nursing aid positions require considerably less education and are over-represented with minority groups.

The authors also make an argument for the definition of caring labor-meaning to look after others as part of a job- as distinct from emotional labor, which fits Hochschild's ideas about the control of emotions as part of work. While overlaps occur, especially in nursing, this teasing out of the terminology is useful. Emotional labor was found to be more problematic than the caring labor (Bullock & Waugh, 2004). Additionally, the field of nursing, across its hierarchies, is questioned as a family-friendly field, with persistence of long working hours, shift work, rotating schedules and culture of sacrifice. However, most of women found ways to balance their family demands. The concept of "caregiving around the clock" was seen paradoxically as source of pride and strain (Bullock & Waugh, 2004). This tension around constant caregiving is reflected in one of the interview questions of this study, "How does your work as a nurse impact the rest of your life?"

The nurses interviewed by Bullock and Wagner all professed their caring labor was "important, socially meaningful work"(p. 773). The RNs, typically in a more supervisory role in long-term care, reported missing the human connection of care work, while the aides framed their caring labor as essential, despite being overworked and undervalued. This revaluing of their caring labor provided the aides with a way to cope with their lack of status, and to make meaning of their efforts beyond pay. The concept of revaluing is further explored with the research interview questions that ask about meaning in work as a nurse and the meaning of caring in paid labor.

An article in the *Journal of Advanced Nursing* compared the differences between physicians' and nurses' stories about ethical challenges in their work (Uden 1992). They often told very different stories. Physicians' stories were focused on making tough decisions and a sense of personal responsibility. In contrast, nurses' stories were more often about when they felt they knew the right course of action, but were unable to act, reflecting a lack of power within a medical dominancy. Doctors spoke of isolation and in the first-person while nurses spoke of social support and used group descriptors. Nurses reported to be better connected to the patient and focused on quality of life, while doctors resented the nurses' claim on "connection." One physician said the nurses criticized doctors, but did not want actual responsibility, just a claim to the moral high ground.

The authors point to the physicians' exposure to research and experience outside of the hospital within the continuum of patient care as the possible source of the differences in group perspectives, citing the nurses limited range of patient experiences while confined to working in a hospital ward (Uden 1992). Conversely, I would argue the difference in viewpoints is not the limitation of nursing experiences, but rather the varying viewpoints of two separate professions in the healthcare field. Nurses and physicians have different education, different focuses and ultimately different jobs. This study shows these differences in one arena, but ultimately misses the point of the two distinctive frameworks around ethical reasoning as reflective of a larger paradigm schism between medicine and nursing. The very notion that doctors know more about ethics is reflective of the hierarchy in healthcare that devalues nurses' knowledge, reasoning and position, likely because of the emotional and caring components of their work. It is not necessarily a limitation of nursing to value quality of life, to consider the patient as a person beyond their health. Arguably, this focus is the crux of what separates the nurse's worldview

from that of the physician. Conflicts and tensions can arise in healthcare from the variation in perspective that colors interpretations of events.

Deborah Talbot takes eight London women who reported a good birth experience and tries to find common themes among their stories (2014). The concept of a good birth is examined from multiple perspectives. The medical model is described as lacking maternal and fetal death, while the natural childbirth perspective has the good birth as lacking unnecessary interventions, thus natural. Additionally, a third framework, known as “dignity in childbirth,” is defines a good birth as rooted in respect for the birthing mother’s choices, not in natural or medical approach. The author appears to favor this approach and works to explore the narrative of the good birth, instead of the typical focus on the traumatic births. From a larger sample of open-ended qualitative interviews of 28 London new mothers, only eight described their birth as good or great. One common thread between the women was a self-described “strong personality” and defined formed views on childbirth. The women, on a whole, described their care in labor as respectful. The third theme was a sense of empowerment or satisfaction with the birth, in conjunction with a positive experience as a mother. The author argues childbirth is a psychosocial event (p. 859), and that women’s experiences, whether traumatic, empowering or something else, are subject to many factors beyond the physical act of giving birth.

With the increasingly technological birth in the hospital, the actual work of the OB nurse shifted. The ubiquity of epidural pain management during labor has impacted the nursing care. Attempts to clarify and categorize what the nurse does beyond clinical, medical tasks, particularly in the medical birth can be convoluted. Labor support behaviors (LSB) is the term coined by Bianchi and Adams in an article in *Nursing for Women’s Health* (2009). LSBs may seem intuitive to the OB RN, including things like making eye contact and providing

encouragement. By describing the work of the OB RN in the intrapartum phase in the typical hospital birth, the often ingrained and automatic actions of the nurse are named, recognized as work, despite the seemingly self-evident nature.

Emotional labor

In *The Managed Heart*, Arlie Russell Hochschild defined emotional labor as the commercialization of feelings through controlling emotions strategically as a job requirement (1983). Her work was groundbreaking and remains a classic. By interviewing flight attendants in the 1980s, she described the ways the service economy placed emotional demands on workers. The realm of private feelings was now subject to the “proper” display of emotions, according to the direction of the employer. Women, according to Hochschild, perform this emotion management disproportionately (p. 20). Historically, women have been caregivers, setting the emotional tone by following rules of display of emotion. Now the service-driven economy has taken advantage of this skill, changing emotion management into emotional labor. By performing emotional labor, Hochschild states there is a “transmutation of an emotional system” (p. 19) by performing emotions out of sync with genuine feelings, under the purveyance of the company rules.

Hochschild looked to the literature and found labor studies, study of emotions and studies of interaction like Erving Goffman (1959). However, her work in *The Managed Heart* (1983) was groundbreaking because she combined these three areas through her examination of emotional labor. While Hochschild gives credit to the influence of Goffman’s focus on the nuances of social interactions and rules, she analyzes the implications of feelings supervised for profit (p. 10).

Hochschild looks also at the underlying inequality reflected in the pressures of emotional labor, particularly when it is troublesome for the worker. She takes the example of a flight attendant told by management that she was too sensitive, after becoming angry with a male passenger that demanded a smile (p. 196). By placing the blame on the worker, the commercial purpose supersedes the inherent inequality in the interaction. Hochschild writes,

It does not signal a perception about how emotional display maintains unequal power between women and men, and between employees and employers. It indicated something is wrong with the worker, not something wrong with the assumptions of the customer or the company. (pp. 196-197)

With the concept “shadow labor,” Hochschild (1983) describes the invisible efforts that often go unnoticed (p. 167), which pertains to nursing as well. Emotional labor can be a type of shadow labor because it is so often performed without conscious thought or discussion, but Hochschild is referring to the tyranny of “niceness” for women that supports subordination (pp. 167-168). Additionally, the lack of control over working conditions and the continuing pressure from superiors adds up to burnout or unsustainability (p. 189).

Emotional labor is a topic that has been explored across many disciplines, including nursing. The increasing pressure on nurses to have patient’s rate their care as “excellent” has pushed the work of managing emotions for nursing to a new level. The arena of OB nursing allows for a gamut of emotional experiences, from the joy of birth, fear with emergent cases, grief with perinatal loss or frustration with a co-worker. These emotions require effort to control and this work is an expected essential part of nursing.

Sharon Bolton's article "Who Cares? Offering Emotion Work as a 'Gift' in the Nursing Labour Process" (2000) raises the question of what it means to care as a professional. She applies Hochschild's emotional labor theory in her qualitative research with gynecology nurses in the UK. Bolton posits that Hochschild's conception of emotion labor does not account for the "gift" of honest emotional care provided by nurses that is not necessarily a performance. By focusing on nurses' professional detachment and managed emotions, the actual experience of care-work is not accounted. Bolton's nurses echoed other research that nurses see their work as a vocation, as a blend of "nurturing rationality" (p. 586).

The president of the American Nurses Association Pamela Cipriano spoke out to nurses and the healthcare industry in an open letter, highlighting the long term consequences possible from emotional labor (2015). She argues that while nurses work in complex, stressful situations daily with inherent emotional labor, the effects can be lessened by improving the support, recognition, and safety of nurses. Ultimately, "what's good for nurses is good for patients"(Cipriano 2015). Foremost, Cipriano acknowledges the significant role of emotional labor in nursing. Second, there's a call to bolster the working environment of nurses. This call to action is the bridge between Hoschild's emotional labor and Suzanne Gordon's *Nursing Against the Odds: From Silence to Voice*. This is reflected in the questions of the research and in the responses of the participants. The nurses complain of the charting burden, the patient assignment, lack of resources, management out of touch, disrespectful physicians, broken systems, but the emotional labor seems to be taken for granted. If the healthcare system better enabled nurses to care...

Nurses talk of "connecting with patients" as a fulfilling part of the work. However, connectedness is difficult to define. The concept is vague and diffuse, more like a feeling than

concrete. In a concept analysis of “connectedness” in the *Journal of Advanced Nursing*, researchers called for a more universal definition (Dinkins 2011).

The role of the researcher is artificially divided from the research, in a ploy to give the illusion of real science, to remove the taint of bias. However, there ought to be an intellectual space for considering how the researcher’s experiences and perspectives influence their work. It is a false construct to ignore our social experiences, to pretend that we are not informed or shaped by what we live. In fact, that is essentially the beauty of qualitative research, to seek to understand our lives by studying the minutia of interactions. Participant observation requires a splitting of attention, a way of looking at our experiences from the outside and simultaneously as an insider.

This reflexive way of thinking, putting a mirror to what our experiences may mean also can be applied to asking OB nurses about their experiences as a patient. A question about their how their birth or other hospitalization shaped their approach to nursing practice allows the OB nurse to think about playing the patient, both in birth and other medical contexts. While collecting birth stories has a place, the aim of questioning how giving birth impacts an OB nurse pushes for that reflexive action, holding a mirror back at their personal lives in conjunction with professional. For some, it could align and for others, there may be more of a collision.

In the article, “The Childbirth Experience: An Obstetrical Nurse’s Perspective,” the author looks at how being pregnant and the birth of her first child affected her work as a labor and delivery nurse. She writes, “I try to take my experience and incorporate it into my practice to provide the best childbirth experience possible for my patients.” This OB nurse relates stories of frequently being asked about her birthing experience by patients and reported “feeling a void” in her care prior to becoming a mother herself. She stops short of claiming she became a better

nurse, instead purports to have a different approach with her understanding. This assertion sidesteps a value-laden premise, that to properly provide nursing care, one must have personal experience in that area. For childless nurses, whether from choice or happenstance, this line of reasoning could possibly be a sensitive topic, particularly if childless implies incompetent. This tension is further explored by asking OB nurses about their childbirth experiences or lack thereof.

The legend of the “Nurse Curse” in OB has also been scientifically examined (Yang, Kao, Chou, Huang, Chang and Chien 2104). One of the superstitions held among OB nurses is that they have notoriously difficult pregnancies and complicated deliveries. A study was done to look at the prevalence of childbirth complications like preterm labor, etc., in healthcare workers in comparison to the general population. Surprisingly, the “Nurse Curse” might not be just an unfounded superstition. In fact, healthcare providers were more likely to have complications in pregnancy in a large scale quantitative study in Taiwan comparing the general population and nurses with birth outcomes (Chang et al 2014). Nurses were found to have “higher rates of cesarean section, tocolysis and pre-term labor” (p. 265). The authors point to a greater understanding of preterm labor symptoms by nurses may lead to a greater recognition and treatment of symptoms with tocolysis. However, this correlation of increased poor birth outcomes in nurses may be further linked to the toll on the pregnant body subjected to typical working conditions of nursing at the hospital, i.e. long shifts, physical labor and notorious lack of rest, breaks and dehydration.

In an article in *JOGNN*, authors Parker, Swanson and Frunchak detail their qualitative research with labor and delivery nurses in Quebec (2014). Ten nurses were interviewed about their needs related to providing care to patients terminating a pregnancy. This clinical situation

may be fraught with ethical and emotional concerns for the nurses as well as the patients. Often, pregnancy termination within a hospital setting is secondary to fetal malformation or chromosomal abnormalities, while elective abortions are done within an outpatient setting. Labor and delivery nurses can be charged with caring for a woman in labor and a woman undergoing a pregnancy loss or termination.

The nurses reported emotion strain heightened by the contrast of caring for birthing patients with loss (Parker et al 2014). Additionally, lack of resources, time constraints, unfamiliar processes and inadequate education may cause further distress for nurses caring for patients with a pregnancy termination. In the research, nurses described the themes of interpersonal and intrapersonal support as a need, along with addressing resource needs. Requests for further education on the topics around pregnancy termination, such as a better understanding of genetic abnormalities, were outlined. Also, the physical and emotional workload associated with this patient population was discussed as a burden within a larger patient assignment, as there are unique needs for this type of nursing care. Nurses wanted to be able to know more about what went wrong with these pregnancies to answer questions for their patients, they wanted the dedicated time and resources to support them, and they wanted advice from their experienced colleagues on how to provide the best care. Perhaps inadvertently, these authors uncovered the nature of emotional work of OB nurses working without proper support and resources, by addressing what they perceived to need. In the research questions of this study, OB nurses in were asked about coping with ethical challenges in their practice.

Davina Allen is a UK based nurse scholar and medical sociologist who offered an insider perspective at the intersection of her two areas of expertise, nursing and sociology. Prior to reviewing texts designed for the overlap in disciplines, she examines this “uneasy marriage

(2001).” As the nursing discipline grew out of the shadow of medicine, sociological concepts were applied, and qualitative methods embraced. Allen cites critic of nursing, with arguments that nursing research was often merely descriptive and theoretical concepts were watered down. Allen posits that nurses gravitate towards qualitative research because of their occupation’s orientation to relationship-based care, focusing on perceptions instead of actions or hard data (p. 389). In response to the lack of theoretical basis in nursing, Allen argues the description-based research typical of nursing holds offers more practical applications than pure theory (p.389).

However, Allen may be missing a point here. Nursing does pull from various fields, beyond sociology, and the ability to combine these influences is what makes it dynamic. Instead of defending nursing from claims of illegitimacy and unprofessional standing, perhaps it is time to applaud how seamlessly nursing can pull together medical, social and emotional knowledge within complex institutions. Ultimately, Allen champions the what nurses can offer sociology, saying, “Nurses have much to contribute to the study of health and illness. Nurses bring to their research an insider-knowledge of health-care systems (p. 390).

In another article, Allen discusses how nurses are constantly using Foucault’s “medical gaze” (Allen 1997 p. 511), surveilling patients, symptoms, technology and environment, to monitor for disease. For nursing, this manifests as the nursing assessment, the continuous process of watching signs and symptoms in the patient. Many of the nurses interviewed saw themselves as the “the doctor’s eyes and ears” with the patients, expressing the value of their monitoring. This can also be conceptualized as the extension of technocratic birth model of Robbie Floyd-Davis.

Davina Allen has taken Disch’s anthem of “making the glue red” and attempted to identify a central piece of that unseen work. In her book, *The Invisible Work of Nurses*, Allen

pinpoints the work of organizing in nursing care as that glue, particularly with the shifting nature of providing care within changing clinical indicators and anticipating changes. Not focusing on simply nurse managers or bedside nursing, she is referring to the ad hoc organizing and reorganizing, with shifting priorities, that come with admissions, discharges, and changes in patient conditions that require flexibility and attention from nurses (Allen 2015). This is not emotional labor, but rather organizing labor that is invisible and undervalued. This may also be another aspect of “women’s work” with managing the household and activities; yet for nurses, it is managing the patient’s progress and scheduling.

Data and Methods

With the purpose of understanding the nature of the work of OB nurses from a sociological viewpoint, a qualitative approach was employed to better capture the nuances of experience. After a preliminary literature review, a set of interview questions was developed. The questions were organized around three main topics. Nurses were asked about their views on occupational culture, the influence of societal forces on their work, and the role of emotions in their work life. Many of the questions were inspired by issues raised in the literature review. The open-ended guide included 49 main questions, available in the appendix.

Next, approval for research was sought from the Institutional Review Board (IRB) from DePaul University. As OB RNs were recruited from many different hospitals to account for a variety of experiences, hospital system IRB was not considered. Several documents were created, including a flyer for recruitment, an informed consent form, and sample recruitment scripts. These are included in the appendix. After submission and obtaining approval from the DePaul University IRB for research with human subjects, the process of recruitment began.

Within my social network of current and former obstetrical nurses from various institutions from ten years of experience in the field, I reached out in person with an informational flyer, via email and attempted a Facebook group for recruitment. A convenience sampling was used with colleagues from both of my workplaces, independent of the institution's sponsorship to avoid confidentiality concerns. A participant may have been hesitant to honestly share criticism and negative comments related to their work if their employer was linked to the study in any way.

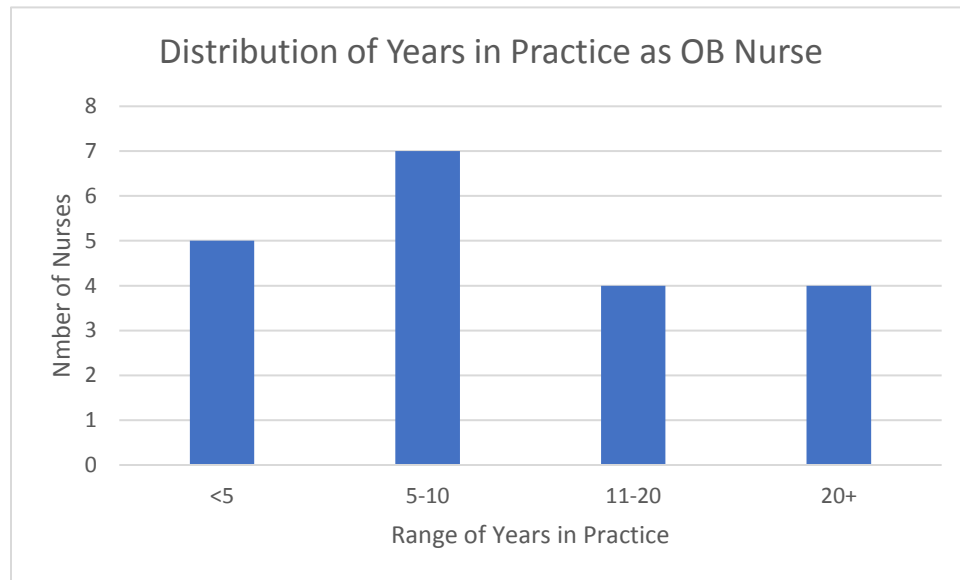
A waiver of documentation of consent was obtained to further protect study participants' confidentiality. Signing a document, even if it is a consent form, creates a concrete link of the name of the participant to the research. An interview may include more candid statements and reach a different level of discussion if the participant is confident their name is not recorded. Employees were asked to openly discuss the nature of their employment, and though not likely, it is possible that a participant may not want his or her employer to know precisely what was said. In addition to convenience sampling, flyers were given to participants to share, and recruitment efforts were made at a nursing research conference and clinical education events.

The target sample was twenty interviews, which was achieved. The interviews were audio-recorded and later transcribed. Interviews lasted from the shortest at 43 minutes to the longest at 134 minutes. Typically, the interview lasted about an hour and a half. There was no monetary incentive given for participation. Participants were interviewed in a place of their choosing, whether their home, my home or a private room at a library, for example. Most opted to be interviewed at home. Participants were given a copy of the consent and interview questions prior to the interview, although several confessed they had not read the questions prior to the interview.

The audio-recordings were analyzed only by the primary researcher and the participants given pseudonyms randomly generated from a website. Identifiable names of hospitals, co-workers, providers and patients were omitted and/or generalized. All participants were women, reflecting the high percentage of female nurses. Attempts were made to interview male nurses, but the field of obstetrics nursing is largely female-dominated. Sample bias possibilities include a focus on Midwestern urban hospital-based OB nursing. The sampled nurses identified mostly middle-class and Caucasian, which reflects the larger nursing population, but there was representation from members of several racial and ethnic groups. The following table shows the self-identified racial and ethnic breakdown of the participants:

Participant identifies as:	Number of participants
Caucasian	12
Hispanic	6
Asian	3
Jewish	1
Mixed Race	1

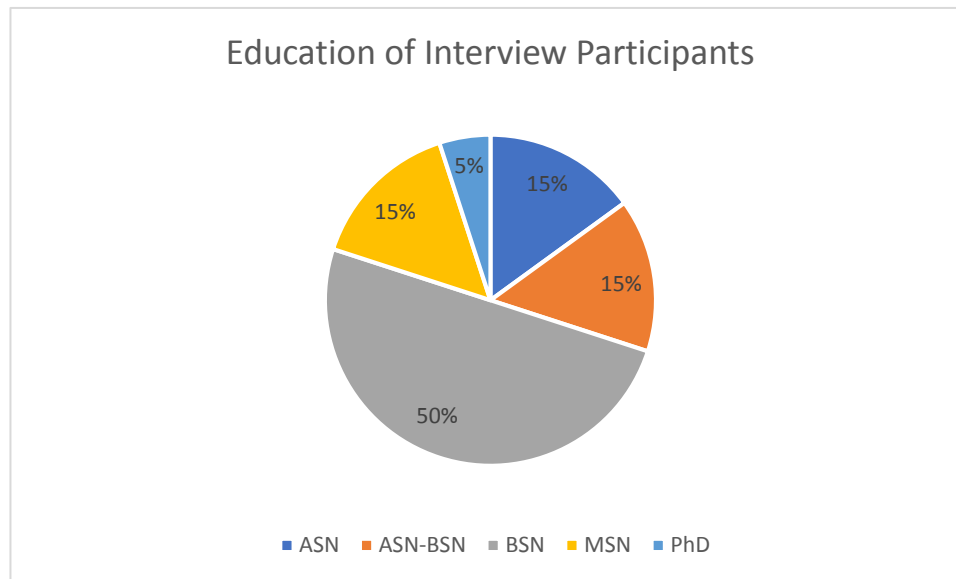
The experience level ranged from 18 months to over 40 years, with a mean of 15.6 years of overall nursing practice, and a combined 313.5 years of nursing work. Within that group, a mean of 11.7 years were specifically OB nursing experience, and a combined 233 years in the



field.

Aside from OB, registered nurses interviewed worked in various other specialties, including: OB home health, neonatal intensive care unit, infertility, postpartum, stroke unit, outpatient clinic, nursing education, nursing informatics, rehab, intensive care unit, telemetry, midwifery, oncology, pediatrics, outpatient chemotherapy, plastic surgery, neurology, emergency room, operating room, nursing home, dialysis, general medical/surgical, school nurse, pre-operative, and post-anesthesia care unit. Additionally, seven of the twenty participants had changed careers to become a nurse, with previous work experience in finance, education, politics, business, and social services. Seven participants had worked as a nurse technician prior to finishing to becoming RNs. Four of the participants were no longer working in the field of OB nursing. This variation in background and overall nursing experience added valuable distinctions to perceptions of their occupation.

The educational background was distributed on a bell curve, with several possessing associate degrees, the half with bachelor's degrees in nursing and several holding advanced post-baccalaureate degrees. See the figure below for a chart.



One former postpartum nurse was a current practicing certified nurse midwife (CNM), which offered insight into the transition from staff nurse to provider. Another participant had completed her schooling and was just beginning her new job as a CNM. Three participants had been trained as nurses in other countries prior to coming to the US. Despite the majority of participants had practiced in the Chicagoland area, there was some geographic diversity in the sample with the telephone interviews with nurses from Texas, California and Florida. While three interviews were conducted via phone because of geographic constraints, the rest were in person. The possibility of regional differences in OB nurse culture could justify the variation in methodology. Also, some had worked in OB in different hospitals, different cities and different countries in various points in their careers, so the effect of the Midwestern urban bias may be partially mitigated. Locations nurses interviewed had worked included Mexico, California, Texas, Middle East, Indiana, Ohio, Philippines, Las Vegas, California, and West Virginia.

The interviews were transcribed and analyzed for insight, common themes and continuity. The words of the OB nurses have been used whenever possible to capture their voice. Prior to the interview beginning, participants were informed the goal of capturing their perspective and the attempted passive role of the interviewer. The purpose of the meeting was verbalized to conduct an interview, not to hold a conversation. This disclaimer was necessary prior to beginning the interview, as nurses are trained to be therapeutic listeners and to elicit conversation to put others at ease.

Acknowledging the expertise and autonomy of the participants underscores the need to respect the value of the experience of the OB nurse. The word participant is purposefully used. Referring to the person being interviewed “a subject” can create a false sense of clinical detachment and removes the collaborative nature of the project. A central purpose is to listen to the voices of nurses and to make their work visible in the academic sphere. A subject is something that is studied while a participant is someone who actively plays a role in the research. Commonly used language reflects the underlying power dynamics that impact interactions, and this is further explored within the context of the participants’ stories.

Overall, an inductive methodology was employed, in the tradition of Glasner and Strauss’ grounded theory. The interview guide was purposefully created with open-ended questions, inviting uncertainty of responses. Although having insider knowledge on the occupational culture of OB nurses, I wanted the participants to describe their perceptions, especially within the context of emotions at work. While conducting the interviews, repetitive ideas became noticeable, producing key phrases and that emerged as themes. Occasionally, I would be surprised at how differently one nurse shared her thoughts compared to another’s story. Within the variety of narratives and individual perspectives shared, threads of continuity fit together

across the interview data. While transcribing, reviewing recordings and transcripts, a collection of conceptual themes emerged from the words of the OB nurses, fitting together in a broader story of the occupational world of OB nurses.

The book “Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory” by Anselm Strauss and Juliet Corbin, a trained nurse and qualitative health researcher, served as a primer of how to methodically approach the analysis. According to Strauss and Corbin, grounded theory is “derived from data, systematically gathered and analyzed through the research process” (1998 p. 12). Applying this approach in research leads to more than conjecture, but rather serves to “offer insight, enhance understanding, and provide a meaningful guide to action” (1998 p. 12). By defining analysis as the “interplay” between the data and the researcher, the layered nature of qualitative research is depicted as more than a step-by-step, cold, scientific approach, but rather an evolving process. Coding is the essence of how qualitative data becomes concepts and then theory. Process is central tenet in Strauss and Corbin’s work, distinct from structure. In order to code qualitative data, researchers should look for categories and concepts, trying to understand the relationships. Identifying the “why” describes structure, but figuring out “how” distinguishes process, thus adding another layer to analysis (Strauss and Corbin p. 127).

Howard Becker’s “Tricks of the Trade: How to Think about Your Research While You are Doing It” uses a similar framework in the exercise of “creating the machine. (Becker 1998 p. 39)” The mental exercise serves to tease out the structural conditions that shape phenomenon by imagining what components of a society machine would produce particular results, or a product. This is somewhat analogous to Strauss and Corbin’s construct, with structure as the machine and the process as the machine’s product. Additionally, Becker advises researchers to ask

participants the question “How?” instead of “Why?” to avoid defensiveness and to better understand the perception of events or interactions (1998, pp. 58-60). Also, the concept of understanding narrative and process in research is echoed in Becker’s work, especially when applied to asking questions (pp. 60-63). Creating open-ended questions requires knowing how to ask people to tell their version of the story, to describe how things happen in their worldview.

Strauss and Corbin’s discussion of how to actually perform qualitative analysis were useful. By advising to focus on more than the problematic in research, they suggest that examining the routine may reveal much about the structures, processes and the self-perpetuating nature of the social world (p. 133). Becker also discusses this very topic, admonishing social scientists to pay attention when “nothing is happening. (pp. 95-98).

The idea of “developing sensitivity to meaning” in qualitative research means a researcher looks to the data for theory, instead of imposing theory onto the data, while holding the paradigm of the research participants in comparison with the researcher’s own worldview (Strauss and Corbin p. 47). This tension lies at the very heart of critics of qualitative research validity, that the researcher is not objective. However, the shifting of perspectives and the quest to understand the way a participant perceives is precisely what makes this type of inquiry complicated and interesting.

In vivo codes serve as another valuable tool in qualitative research. When a participant uses a term that captures the essence of a theme, the in vivo code comes directly from their words (Strauss and Corbin pp. 117-118). This practical and ingeniously simple coding takes precisely what the participants say in real life, captures their way of seeing, and applies it analytically. In vivo codes reflect the inductive method, pulling the categories and concepts from the research. While using a grounded theory approach, the experts caution against attempting to

“retrofit” an existing theory from the literature. Although established theories may be applicable to the data, it may not be entirely representative, so innovation and creativity are advised (Strauss and Corbin pp. 155-156).

An article from the *Journal of Advanced Nursing* looks further into qualitative nursing research and the significance in stories. In “Storytelling and Interpretation of Meaning in Qualitative Research” (2002), Bailey and Tilley interviewed patients with chronic health exacerbations, and their narrative analysis provides further insight into the practice of performing qualitative health research. While they focused on patient’s making meaning of their experience through telling stories, these practices can also be applied to the stories nurses tell to make sense of their work experiences. This emphasis on the crucial importance of stories moves beyond the clinical focus of the RN’s work and into the “truth of their experience, not an objective decontextualized truth” (p. 581).

The significance of the story was also addressed by Strauss and Corbin, as a theory-building tactic. Stretching from identified themes to theory can be challenging and various strategies are discussed, including concept mapping, diagram creation, memo sorting and writing the storyline (143-156). The techniques of writing the storyline and memo sorting were utilized in this project. First, memos, or notes, were written about possible themes from the data. Then, the memos were sorted, clustered and developed through analysis into themes. These themes were ultimately brought together in a narrative to describe the world of obstetrical nurses, and how their perspectives can inform understanding of the macro social universe.

Reflexivity

Qualitative research is plagued by critiques of bias and lack of objectivity. While qualitative analysis contains personal biases and is not always technically objective, it does allow for a more nuanced, closer examination of experiences and perceptions. Instead of claiming to be universal or causal, the interviews in this research project try to uncover the reality of the lived experiences in this occupational world. My interest in OB RNs is more than academic because of a personal desire to make sense of the last decade of my working life.

This project has challenged me to try to think about my work in a whole different way. However, I have always been evaluating my job as an OB nurse from a sociological perspective since I started ten years ago. Before nursing school, I had attended graduate school for sociology. Even working as a nurse, there is a separate analytical part that cannot be turned off, always looking at the patterns of interaction and the way things tend to work. I had read Lois Wacquant's *Body and Soul: Notebooks of an Apprentice Boxer* (2004) many years ago, but a few of the ideas stuck with me. French sociologist Wacquant was studying at the University of Chicago and thought that Hyde Park seemed disconnected from the neighboring areas. He decided to join a boxing club on Chicago's south side, moving out of the academic social circle. He kept intensive notebooks and, in some ways, treated the experience similar to fieldwork research. After falling in love with boxing as a sport, he considered pursuing it competitively as a new career.

Wacquant's book (2004) does an excellent job of examining the role of a researcher in a community and takes care to consider the ethics of studying real people. By examining what it means for a researcher to enter the research, he makes an elegant argument for the validity of ethnographic research. The concept of "habitus" is borrowed from the theories of Pierre Bourdieu and applied to boxing. Habitus can be thought of as a learned way of perceiving and

interacting with the world. This socially constructed way of interacting understands the impact of the physical aspects of an activity, akin to the idea of “muscle memory.” Wacquant argues by physically learning the sport of boxing, he understands it on a level that a spectator, an outsider, could not. Knowing the habitus of boxing allowed him to understand better the experiences of boxers, and to connect on a different level. Instead of mere observation, he walks an imaginary line by “going native”, to borrow the historic terminology of anthropology. This tension between research and participation is fascinating.

His insights are much richer and ring truer because he lived, in his own way, the experience of a boxer (Wacquant 2004). To know what it feels like to face an opponent in a ring in a fight requires more than an understanding of the sport’s rules or analyzing the descriptions relayed. For one boxer to talk to another, they can use a shared language, a type of shorthand, and can discuss nuances without having to explain every background detail. For example, discussing training among boxers could have a physical component since the habitus of boxing becomes ingrained.

I often thought of Wacquant’s book while I learned to become an OB nurse. I sometimes felt like I was becoming part of a culture and knew that allowed me to understand this new culture in a different way. In doing this research project on OB nurses, one of the more challenging aspects has been to pull my familiarity away, to reframe what is routine with a new way of looking at it. Davina Allen, nurse and sociologist, said, “The challenge for nurses of course is to make the familiar strange and to use this insider knowledge to inform the research, and then to stand back from it and study it in a sociologically informed way (Allen 2001 p. 390).”

I thought about Wacquant's habitus as I learned to start IVs, draw blood proficiently, position patients, spike a new bag, program a pump, how to steer a bed and swaddle a baby. I think about those physical skills and wonder what it would mean if I will lose my proficiency as I work less on the OB floor. I have accumulated more than clinical skills because I built a habitus of OB nursing. A personal satisfaction arises in being proficient and skillful. I suspect most nursing jobs have their own habitus.

Setting

According to Howard Becker, one of the maxims of research is "Everything has to be someplace (p. 51)." This basic assertion belies a larger idea, that all research is gathered from an environment, and the details that make up this setting are not just background information. The setting is the conditions of the research, influencing the structure and the interactions and cannot be overlooked (Becker pp. 51-57).

Let us introduce a typical setting of birth in America. The vast majority of births in the United States occur inside a hospital on a Labor and Delivery unit. Labor and Delivery, commonly known as L&D, is subset of obstetrical care that also includes surgical procedures. In obstetrical nursing, there is also Post-partum and Well-Baby, also called Mother-Baby or Mom/Baby. In some hospitals, the obstetrical care is combined into one unit, known by the acronym LDRP (Labor/Delivery/Recovery/Postpartum). If a nurse works in a hospital with LDRP, she is trained to take care of women from antepartum complications, throughout labor, birth, possibly surgery, recovery, postpartum, provide newborn care and lactation support. This system purports to allow for flexibility in staffing nurses and consolidating services into one area. Theoretically, a pregnant patient could be admitted to a hospital, in labor, give birth, recover and be discharged all from the same room with same nurse the entire time, although that

is unlikely given the length of a typical obstetrical visit. Nurses who work LDRP are trained in all areas of maternity care and may be assigned to different types of patient in each shift.

Another common system is to have L&D, along with the OB operating rooms, separate from the postpartum unit. After a woman gives birth and finishes recovery, typically 1-2 hours, she is moved to a different area, often another floor, with her infant. Although postpartum refers to the mother, most commonly infants are kept with their mothers after birth for bonding, known as couplet care. The days of newborns in bassinets neatly lined up in a nursery window are gone, for the most part. This means a postpartum nurse works “mom-baby” and is often responsible for caring for couplets. Antepartum care includes pregnancy complications that occur prior to delivery that require hospitalizations, is sometimes provided on the L&D floor or on the postpartum floor. If antepartum patients are cared for on the post-partum floor, problems may arise if the patient is delivering without the proper laboring resources. Some post-partum nurses may lack the experience and training to care for these antepartum, still pregnant, patients.

In the world of medicine, physicians are trained as obstetricians and gynecologists in a combined role. Some will further specialize in gynecology, which tends to focus on the female reproductive organs, not on actual reproduction. OB/Gynes are trained surgeons and often work with women across the lifespan. However, gynecology typically is separate from OB for nurses that work in a hospital setting. Occasionally, a postpartum unit will take a patient post-gynecological surgery if the census allows. Gyne patients fill an empty bed and make more revenue for the OB floor. Some hospitals frequently have gyne patients on the postpartum floor or wing, but some rarely do. The gyne patient is an exception to the routine, and OB nurses may not have the same level of training or expertise to care for them.

The OB unit is a locked ward, just like the psychiatric floor. Sometimes people will come to the door and ask to see the babies, like in an old movie. Usually this is a nostalgic person or a saddened hospital visitor looking to be cheered up at the prospect of new life. After being buzzed into the unit, the anonymous visitor is sent away, being told “We don’t do that anymore.” The locked ward is a safety precaution against infant abductions, as are the electronic monitoring bracelets worn by infants across hospitals. Code Pink or Code Adam are often the infant abduction hospital-wide warning systems, which are hopefully only practiced in mock drills.

On the OB unit (or floor or ward), usually there are wings that are filled with hallways of numbered rooms, like most other hospital floors. Each patient is assigned a room. Some hospitals have cluttered halls full of miscellaneous equipment, despite regulations to keep hallways clear. The walls are probably painted in muted pastels or light earth tones with bland art. Patients are frequently referred to by their assigned room number. For example, a doctor may ask a nurse, “Do you know who has 604?” meaning which nurse is assigned to care for the patient assigned to room 604. A tech may call a nurse, saying “5 is asking for pain medicine.” There are also sometimes alcoves in the main halls, “cubbies” or “pods” where electronic monitoring and documentation takes place by nurses, although most institutions push for charting at the bedside.

There is typically a central nurses’ station, board room or breakroom. This central area is where change-of-shift report may be held, assignments posted, and central monitoring of patients’ labor progress. The “board” refers to the list of current labor patients and their progress. This maybe electronically posted on a large screen, but may still be an actual dry-erase, large, white board. Often, OB departments are distinguished whether they have residents or not. If there are OB residents, this constitutes a “teaching hospital” which can be quite different than a community hospital. Residency is the period that newly graduated medical students learn their

specialties. Medical students are low in the hospital power structure. They have no authority, often simply observe or doing menial tasks, like hold a retraction instrument in surgery. Once graduated as doctors, new residents work supervised by experienced residents and supervising physicians, called attendings.

For an OB nurse, working with residents means there is an intermediary between the RN and attending physician. The nurse will discuss the plan of care, receive orders and notify the resident of concerns and critical values. The resident then relays the information as necessary to the attending, who ultimately dictates the course of care. In a teaching hospital, residents are typically “in-house” meaning, they work in assigned shifts and there is continuous physician coverage of all hospitalized patients in labor. The nurse rarely directly contacts the attending physician, who may be off-site, unless there is an emergency or a concern that goes up the proverbial chain of command. Often, the attending physician, or whoever is on call, will come in solely to attend the birth. Quite possibly, the patient can never see the doctor who provided their prenatal care during their hospitalization. Despite years of experience and certifications, OB RNs may need to defer to a new resident’s medical decision-making.

In contrast, working in a community hospital as an OB RN translates to a much greater autonomy and more responsibility. Here, nurses will perform most cervical exams and whatever interventions allowed, like placing internal monitors or sterile speculum exams, that a resident would typically perform at teaching hospital. The OB RN will be directly contacting the attending physician and discuss the plan of care, once the buffer of the resident is removed. The OB RN has the job of informing attendings of concerns and making sure to time their recommendation to come into the hospital for delivery. In this environment, the nurse is essentially managing the patient per protocols and updating the attending on progress.

This difference between working as an OB RN in a community hospital versus a teaching hospital can be a difficult transition, whether it is gaining responsibility or ceding authority to a resident.

Midwives in the hospital setting are generally certified nurse midwives (CNM), RNs with advanced practice degrees who provide primary care for women with low-risk pregnancies. Their scope of practice varies from state-to-state, with some working independently and some requiring a collaborating physician to practice. The midwifery approach is based in the belief that birth is a normal physiological event, not necessarily requiring medical intervention (Scoggin 1996). Not all midwives are natural birth advocates, although their education includes support these techniques. CNMs may practice in a hospitalized, medicalized manner consistent with prevailing medical interventionist models. Midwives can place orders and function in the hospital hierarchy somewhere likely between residents and attending physicians. OB RNs and CNM may encounter some tension with questions about authority and duties where there is role overlap.

Training as an OB RN is called orientation. Length of orientation varies, based on prior experience and hospital practice. An orientee is assigned a preceptor, a more experienced nurse. There may be a formal plan for orientation or it may be adapted to the needs of the newly hired nurse. An experienced OB RN would expect somewhere from 2 days to several weeks on orientation. As a newly graduated RN, orientation could last from about 10 to 16 weeks. At the end of the orientation period, a nurse is expected to function independently. A nurse that doesn't make it out of orientation or has the time extended may be looked down upon. Some hospital systems have simulation labs for training and while others expect nurses to simply learn as they go. The formality and universality of education varies across institutions. Some nurses may have

a short, uneventful or unproductive orientation, but are expected to perform independently and safely care for patients. The preceptor role may be voluntary or assigned and is not always relished by experienced nurses. Precepting requires teaching and also can take more time to complete tasks.

Technology and Risk

Modern obstetrics is steeped in the concept of risk. Without the context of the litigious contemporary environment, the work of the OB nurse does not seem to make sense. Charting one of the main duties of nursing. It used to mean documenting patient progress and related care on a piece of paper for maintaining continuity and watch for trends. However, charting now is more geared towards “covering yourself,” showing a record of care provided that can absolve the health care team of culpability in the event of a poor outcome. OB nurses know that their specialty is the most sued, and that their charting may be scrutinized in court some future day. This means OB nurses preach the adage, “if it is not charted, it is not done.” If there is not a record of an event or assessment in the documentation in the EMR, then there is not proof.

Most often, laboring patients are hooked up to continuous electronic fetal monitoring and tocodynamometer (toco) of the uterus, known by the acronym, “CEFM/toco.” Women in labor have two things being simultaneously monitored, the heart rate of the fetus and uterine activity. This is achieved by placing two monitors strapped around the laboring woman’s belly. Alternatively, a monitor may be placed on the infant’s scalp, internal fetal monitoring (IFM) or known also as FSE, fetal scalp electrode. This is more accurate, but more invasive. The toco is measuring contractions, rest periods, and uterine activity. Mirroring IFM, there are internal monitors of uterine activity, known as IUPC, that is more invasive, risky and accurate. These two items, whether internal or external, are measured continuously together, producing a “strip.” This strip

used to be paper but is now electronic and can be viewed throughout the unit, known as central monitoring. OB nurse are trained in fetal heart monitoring and may be certified at different levels. The constant surveillance of the strip of the laboring woman is the duty of the OB RN. If there is something questionable or amiss with the strip, the nurse is expected to act, notify and correct the issue as possible. The nurse is also expected to document all interventions, notifications and actions. This is in addition to monitoring the maternal vital signs.

If the fetus shows signs of distress by declines in heart rate or lack of variation in the heart tones, the nurse should know the underlying physiologic mechanism of the decline, known as decelerations or decels. Some decels are more worrisome than others, and this is related to when the dips in heart rate occur in conjunction with the uterine activity. OB nurses spend hours watching these strips, becoming more confident and adept at maintaining continuous tracings. Most OB nurses have taken courses in fetal monitoring and some hold advanced certifications. The standardization and classification of certain patterns have been formalized and standardized in recent years. The quality of the accuracy of monitoring is dependent on monitor placement on the patient's abdomen and the patient's position. So, if a patient is moving frequently in labor, monitoring can be quite a challenge. There are some wireless monitors and portable monitors, but these newer systems for fetal monitoring are not frequently used or totally reliable. This growing technology may hugely impact the work of OB nurse if there is a shift in practice.

Intermittent monitoring of labor is used more frequently by midwives and natural birth advocates. Although it is recommended by various respected nursing and medical groups, it has not gained much traction in the day-to-day operations of the OB floor routines.

Nowadays, hospitals use electronic medical records (EMR) in conjunction with continuous fetal monitoring. In OB, documentation of care comprises a great deal of the nurses'

work. Nurses have required documentation per shift. This typically includes a head-to-toe assessment, care plans, education provided, notes, pain levels, vital signs and interventions. Admissions require a great deal more information to document in the EMR, or “chart.” If a patient is in labor, there are specific documentation expectations of the CEFM/toco, including charting as frequently as every 15 minutes evaluation of the strip. This strip charting is performed by the nurse and supposedly reflects the surveillance and evaluation of fetal distress and uterine activity. It is not uncommon for a nurse to need to catch up on strip charting, which is to document several hours of assessment afterwards.

A patient room on the L&D floor will likely have an OB hospital bed that breaks apart for delivery and stirrups that flip up into place. There will be emergency equipment attached to walls, like oxygen and suction, as well as code buttons. Each patient gets their own call button, known as call light or nurses’ light. Most units issue phones and patients can call directly to their nurse

Work conditions: A day in the life of an OB RN.

Registered nurses (RN) have completed schooling, passed an exam and are issued a nursing license by the state in which they work. There are still a few diploma schools, but the vast majority of nurses have a minimally an associate degree. Increasingly, employers are mandating a bachelor’s degree as the entry level for RNs. Out of nursing school and after passing NCLEX, most RNs will end up working the night shift. In the past, it was not common to hire new nurses into specialties. The rationale was that most nurses should start in general medical-surgical nursing to gain clinical experience and skills. While there are required clinical hours in nursing school, these times are supervised, and the role of the student nurse is constrained. The prevailing thought is new grad RNs belong on the night shift in med-surg. However, some places

will accept new grads into specialty fields like OB. A nurse may come out of school wanting to be an OB nurse, but may not be able to find a job with no experience. An open day shift position for an OB nurse is not common, since the internal night shift OB nurses usually desire to switch to days. A new grad starting on the day shift on OB is atypical.

Subsequently, most OB nurses work days, nights or PMs. More hospitals are moving to offering only 12 hour shifts, with full -time consisting of 36 hours or 0.9 position. Typically, nurses work “days” from 7 AM-7:30 pm or “nights”, 7:00 pm-7:30 am. That extra half hour is reserved for handing off patients, known as report. Giving report is the daily ritual of the working RN. The PM shift is 3 pm-11:30 pm and is usually included in a mixed schedule with some other nurses working 7 am-3:30 pm and 11:00 pm- 7:00 am. This PM shift is losing traction as twelve hour shifts are increasingly the norm. Amongst nurses, much debating occurs around this trend. Some nurses want to only work 3 days a week, while others find the long twelve hour shifts too demanding.

Night shift is usually staffed with less experienced RNs on OB, although there are sometimes outliers, like experienced nurses who got used to working night shift, who like the pay differential, who enjoy the less managed environment, or choose the off-schedule for childcare or other personal reasons. Working nights is a rite of passage and usually most nurses “put their name on the days list” as soon as possible.

On an average shift, a nurse will arrive at the hospital at few minutes early because she has to go to the locker room to change clothes and shoes. OB nurses usually wear hospital issued scrub tops and pants because they must be able to circulate in the operating room if the need for a cesarean section arises. If the nurse drove to work, she should expect to park remotely so patients have easier parking spots available, which can be time consuming. After swiping in, the

nurse must be ready, with a pen in hand to take report from the outgoing nurse. An assignment is given, usually from the outgoing charge nurse. Some hospitals have “huddles” which are mini-meetings to discuss concerns and issues. Some hospitals have an interdisciplinary meeting to quickly present the patients. Other units may simply electronically assign new nurses to respective patients via EMR.

Report is a ritualized handoff between nurses. In OB, there are key pieces of information are presented in a particular order and language. Despite the ubiquity of computerized charting, nurses commonly employ a handwritten report sheet that includes pertinent lab values, medication times, and specific data for the assigned patient. Some hospitals have instituted bedside report, where the nurses are required to complete handoff in the patient’s room. This can be logistically complicated when nurses are getting report on multiple patients from multiple nurses. Interruptions during report can disrupt the flow of the continuity of care, since there is a small window of time to complete this task.

On every shift, there is a charge nurse assigned. At some hospitals, there is a rotating charge system, where the regular staff nurses take turns being in charge through assignment, being paid a couple extra dollars per hour for the extra work. Alternatively, team leaders act as the permanent charge nurses. The charge nurse is tasked with updating the assignment and adjusting staffing as the patient census allows. Giving birth is unpredictable and the flow of patients can shift drastically in one shift. The charge nurse is expected to be a resource, to help in emergencies and to figure out unexpected situations. Additionally, the charge nurse may take a patient assignment, depending on the staffing levels. Most units issue OB nurses hospital phones so they can be reached at all times while working. Providers typically have call rooms to rest in when not engaged in patient care. There is no such place for nurses.

After obtaining report, an OB nurse is expected to round and do an assessment on her assigned patients. If assigned to labor, this is typically one to two women in labor. If assigned to mom-baby, this can be anywhere from 2-5 couplets. The length and depth of the assessment is dependent on the clinical situation. If a laboring patient is stable and resting, this could be quick. If the nurse is assigned to four mother-baby couplets with multiple health issues, this assessment could take hours. The expectation is that nurses chart in real-time to document as they are providing care, but the reality is most OB RNs rush around to cluster all care needed and then perform the time-consuming task of charting later once all the work is complete.

The nurse is expected to review orders from the physicians, administer medications as scheduled, and perform assessments, offer education and provide care as ordered. Within the working world of the hospital, there is a division of labor. Doctors write orders, while nurses carry out these orders. The doctors do not necessarily manage the nurses, but they manage the plan of care, which includes orders. The language of this hierarchy is reflective of the power dynamics. To illustrate the hierarchy on the floor, the chain of command is a useful tool.

On the floor, there are also obstetrical technicians, certified nursing assistants or student nurse externs. On some units, the nurses are trained and expected to “scrub” into surgery, meaning to assist in the sterile procedures in the operating room after performing a rigorous, prescribed hand washing. Alternatively, the nursing assistants are trained as “scrub techs” to assist in the operating room, while the nurse acts as the circulator. Also, there are “first assists” in some community hospitals who are trained surgical assistants that are called in for surgery. This distinction between whether or not the RNs “scrub” in OB varies among institutions, particularly on size, volume and location. Due to the nature of surgical aseptic technique, the role of the scrub is very different than the role of the circulator. While the scrub must maintain

sterility, the circulator moves about the operating room, fetching supplies, documenting and preparing for the birth.

Division of Labor

There is a clear division of labor within most OB departments, whether this is mandated by written policy and protocol or created by norms within practice. The ultimate decision-making capacity lies in the hands of the physician. The chairperson of the department is often the top of the chain of command and is consulted if an issue is not resolved at lower levels. Under the chair, the attending physician is above the resident. If there is a mid-level provider like a midwife, that are somewhere between the nurse and typically their covering physician. The staff nurse is under the charge nurse, who reports to the unit manager or house nursing manager if off-hours. The nursing assistant and technicians ostensibly fall under the RN, although they technically report to the manager.

Findings

Occupational Culture

“Baptism by Fire”: Becoming an OB RN

Becoming an OB RN is a process of “adult socialization,” a concept described by Hughes (2009, p. 295). For the nurses interviewed, the process of training to be an OB RN was difficult overall. Almost every nurse described feeling fearful. Whether the participant was transitioning from another role in nursing, a newly graduated nurse or a career changer, the descriptions of orientation to their jobs were full of uncertainty, a lack of confidence, and an overwhelming sense of fear. Although some nurses espoused a calling to working in obstetrics, all twenty participants described a difficult learning period categorized by fear.

According to Kathy, “I was baptized in fire.” Despite her lack of confidence as a new nurse, she reflects back on her fear, her discomfort as part of the growth into her role. The term “baptized in fire” stands out as a fitting description of the orientation process as an OB RN, across the interviews. Baptism is an interesting choice of words, alluding to a transformation and a religious induction into a group. This conversion narrative is a theme that repeatedly emerged in the interviews, and further supports the concept of occupational identity. The level of intensity of the orientation experience as OB RNs for these participants is reflective in the use of “baptism in fire,” with fire representing the difficulty. This “in vivo” code as a tool for understanding the qualitative research process is described by Corbin and Strauss. (ADD YEAR) This phrase “baptized in fire” takes religious symbolism to sum up how becoming an OB RN incorporates learning through fear as a transformative experience.

Candace describes becoming an OB nurse as follows,

I learned through fear. I was scared all the time. For the first two or three years, I wanted to throw up every time I pulled into the parking lot. I felt an overwhelming responsibility- it was over the top- that I held their life in my hands. Like, I am the thin blue line, holding it together. I didn't have that team sense then and felt that weight.

Several years of work-related anxiety with physical symptoms is the rough end of the spectrum of this baptism by fire. However, her description of holding patients' lives in her hands does impose the feeling of the gravity of her sense of duty. The thin blue line analogy she mentions is not entirely clarified, but the feeling of obligation, pressure and significance she assigns to her work is clear. Whether Candace is referring to the separation of earth's atmosphere from the vastness of space, the role of law enforcement between order and chaos, or something else entirely, this nurse takes her duties very seriously, with fear as a major motivator. By recognizing

her past intensity of feeling on becoming an OB nurse, she further acknowledges her growth into a more team-based mindset to providing care.

This sense of overwhelming responsibility was also a shared insight, further solidified by an instilled fear of litigation. Maryanne sums this up in the following passage: “I kept thinking: It’s not if, it is when I am going to be sued. That was terrifying. That is what they drilled into us in school, that you need insurance, that you have to be so careful. That lawsuits are so rampant. God, I was scared to breathe.” This nurse is touching on part of what drives the basis of fear in OB nursing, the possibility of birth-related trauma, deaths and disabilities. Many seasoned OB nurses will swap tales of being deposed, being intimidated by lawyers, trials that did not go well and multimillion-dollar settlements. While often nurses are not personally financially responsible for these types of lawsuits, their credibility and their nursing judgement is often called into question by these incidents. Respecting the role of risk in birth was a topic engrained in training of the OB RN. The specter of liability and lawsuits becomes a “boogeyman” of sorts, instilling fear and apprehension beyond concern for welfare of patients. The undercurrent of fear in the work can be tempered over time, through experience, exposure and support, as described by the participants.

Let’s take the example of Jody. When asked about becoming an OB RN, she said, “I remember being so scared, not understanding the whole thing. I had critical care experience, but it was so different. And all of the sudden, it clicked. I think it was something I was meant to do. When it clicked, it all made sense and I knew what to do.” Even after working in critical care, which is arguably as stressful and intense as OB, she felt initially frightened by the transition to working in OB. However, she sees her work as a calling, as an occupation that fits her, and

becoming an OB RN was somehow her destiny. The concept of OB nursing as a vocation beyond a job, will be further explored later thematically.

The role of the preceptor, the nurse trainer, was frequently discussed in conjunction with fear. One nurse reported, “My preceptor was very hands-off and made me jump in from the start. I was really scared for a long time and I am still, every time a baby is born.” In the previous statement, the nurse alludes that her fear was worsened by a lack of support by her preceptor. As an assigned mentor, often with little additional training or materials, a preceptor in OB is assigned to train a new OB nurse, working the same shifts side-by-side, but sometimes the match does not work out well. Several of the nurses interviewed had served as a preceptor themselves, with mixed reactions. One nurse described precepting as “frustrating, because it slows you down.” Another reported her precepting experiences as stressful, “because you are expected to teach, yet carry the same assignment as usual with no consideration or time, so it is just extra work.”

However, sometimes, the relationship is recalled fondly despite the difficult circumstances. In the following passage, this nurse Kathy describes her preceptor.

There is one nurse in particular who probably made me the person that I am. I thought she was an Army nurse. The doctors respected her, and she was tough as nails. She had a heart of gold. She taught me just about everything I know. She just what I needed because I was such a wuss when I got out of school. I mean, I was afraid of my own shadow. I wouldn't do anything, and she would make me do stuff that I hated her for. I don't hate her, but I hated it. But she made me do them. When looking back, when it was just her and I on the night shift, I think- ‘Oh my God, she should have won a medal because what I put her through. ‘

These comments were said with tears in her eyes, demonstrating the emotional connection she felt. This nurse saw her preceptor as more than a trainer, as her ideal type for a nurse: one who is respected, strong yet loving, that pushes the novice into growth. Taking into Suzanne Gordon's portrayal of the PR problem of nursing, this ideal nurse as an archetype stands in stark contrast to the saccharine trope of angels armed with TLC. However, by calling herself a "wuss," Kathy spoke self-deprecating about her fear as a novice OB nurse.

In contrast, this next nurse, Suzanne, discusses how supportive her preceptor was and how difficult she found it to work autonomously.

I had the best preceptor. She was so, so patient with me. My orientation had to be extended because I didn't have confidence and I made some mistakes. But then I went to nights when I was ready. It was scary to be on my own. Not only was it hard to lose my preceptor, but I was expected to be confident. With people I didn't know. I didn't know the night people and had only given them report. It was hard. And switching hospitals, I had to prove myself all over again. Even at the interview at the second place, the manager told me in my interview, "You need to show confidence here." I realized, well not at the time, that what she was saying, was "they will eat you alive if you are not confident." I found out what she meant soon enough.

Despite having transitioned from novice to experienced nurse in the OB role, she found herself facing similar issues of fear and feeling isolated at a different hospital. This description of needing to prove oneself reoccurred in the interviews, and the environment was not always described as supportive. An atmosphere of akin to hazing and concerns with confidence were reported, especially in orientation periods or switching jobs. Here, Allison tells about her move to work in OB:

It was hard. Transitioning from sick people to healthy was hard. I felt like other nurses were talking about me, eating their young. Some nurses told me outright that I had a reputation and a bad attitude. I remember sitting in a cubby and crying, not knowing if I should do this. It took me a long time to feel like I was doing a great job. Assumed that on nights, that you are stupid and young. Sounds generational to need a pat on the back, but confidence makes you good.

“Nurses eat their young” was something I heard over and over. This cannibalistic phrase was popularized in 1986 by nurse Judith Messner in an article calling out bullying in nursing, particularly with new nurses. While there is a great deal of literature on the topic, but the practice continues across specialties. Lateral or horizontal violence is the terminology used in the nursing literature, but for most the participants, the adage of “nurses eat their young” persisted. The difference in generations and age gaps between co-workers may play a part. Overall, the OB RNs saw their orientation into their occupation as a difficult, fearful time, a baptism by fire.

Sisterhood & “The Golden Egg”

While the issue of workplace bullying was mentioned, there was a more dualistic nature of the relationships among nurses. OB RNS sometimes saw their culture as a type of sisterhood, comprised of a connection forged through shared stressful experiences, while other voiced frustration at the difficulties of their work environment. Of working with predominantly women, one person told me, “It is good when it is good and bad when it is bad.” Sometimes, these two opposing perspectives were described by the same nurse, a simultaneous sense of closeness and conflict. This type of relationship can be understood as family-like. Because of the nearly exclusively female workforce, the social world of OB RNs was conceptualized as a sisterhood. Consider the words of this nurse.

Our relationships are really close, and I compare it, really loosely, to the military. And policework. Nursing isn't personally dangerous but being in other people's life and death situations together still does create this incredibly strong bond. Because I know that I can rely on you no matter what. That when I call you, you will be there. So, when patients ask, 'Would you have you baby here?' I say, 'Why would I go anywhere else? These are my sisters here. They take the best care possible of you.' It an incredibly strong bond.

Bearing witness to survival situations and sharing accountability for life-altering circumstances contributes to the strength of the occupational culture, the sisterhood amongst co-workers. This may further tie into later discussions of emotional labor in nursing, but here the point revolves around way work can form bonds. She uses the term "sisters" to describe co-workers, drawing comparisons to policework and the military.

Here, in the following passage, an OB nurse explains her view on the relationship with co-workers:

It makes you super-close to people when you have had those traumatic experiences. You can look at a person and know they know what you felt. I imagine it's like people who get deployed and come back. You can't really share those experiences with people who haven't been through them. You can't even tell someone else- you'd have to spend so much time explaining everything. Afterwards, I had told someone else about how I felt about that tough experience that wasn't there. And she called me a year later when she had a bad experience and was feeling really traumatized. She wanted to talk to someone who had been through what she had, wasn't freaking out, and would understand. Nurses have that amongst each other. There is a lot responsibility on you, that you don't share with the techs or the doctors. It's just different.

The analogy to the military reoccurs, with an emphasis on insider understanding. By pointing out that trying to share feelings about problematic cases was too much to try to explain with outsiders, she expresses a distinctive nurse bond. Another nurse refers to the closeness of relationships between nurses in a similar manner, stating,

It's a family, at least where I am. I am so, so thankful. They've become some of my best friends. It is a hard to thing to be in, when most of the time it is so happy, but when it is awful, it's devastating. And to have a group of people to understand that. I have a great husband, but he can't understand what it is like to deliver a dead baby. Nobody can but an OB nurse. It makes you close.

The description fits the sisterhood model, with co-workers as family and as friends. Further discussion of loss, grief and trauma in the workplace is warranted within the context of emotional labor.

However, not all the discussion was positive, just like family relationships. The terms “catty,” and “gossip” were often used in descriptions of the relationships among OB RNs. This nurse offers a clear summary of the negative themes of sisterhood, saying, “It's hard. Hard. It is very catty, clique-y and emotional. But it is hard. 90% have children so scheduling and fairness is difficult. Childcare issues. Different personalities and cultures can be challenging, but at the end of the day, we make it work.” She seems to hint at a resentment at perceived favoritism about preferential scheduling for mothers. When one nurse explained how some of her co-workers would likely never be in her social circle outside of work, she talked of enjoyed having women of different personalities, ages, and cultures in her life. Not surprisingly, diversity among OB nurses was most often mentioned by women of color. Also, age and generational gaps were

referenced as factors in relationships. Although all the participants were female, a few nurses brought up their husbands' work culture in comparison to their own.

Luz explained, "You have to be careful, women are sensitive. My husband works in engineering and he says he will say out in open if he doesn't like something. Their culture is direct. Here, in OB, you have to be careful. "Since women are perceived as more sensitive, greater consideration is required dealing with women, according to her perspective. Next, a nurse offers a mixed review on her impression of being part of the sisterhood.

Catty. That's the first word that comes to mind. Unkind, like we are hormonal. Like the way my husband talks about his work dudes, there is zero drama. Sometimes I wish I were a dude. Sometimes it is terrible working with all women. Sometimes I come home from work, just exhausted. But sometimes, I think it is awesome. Like women put in a lot more effort than men. Like birthday parties, showers, teamwork. Men may have less drama, but less appreciation.

Her assessment is women are sometimes unkind and terrible, but also more appreciative, show more effort, and "awesome." Clearly, she has mixed feelings about her emotionally- invested occupational culture, which she attributes to a female-dominated workplace. Her comments about dudes can also be seen as an occasional desire for a less relationship-based workplace environment.

This nurse Irma's comments offer another perspective on the sisterhood of OB nurses. She states,

Some days can be really fun. Fortunately, we have a great group of girls at work, where we can chat and hang out. And when we have great patients, and a healthy baby. But

some days are not that great, where you are so, so busy, but there is still a sense of "we made it through it." It is very rewarding. I think it is about the relationships that you build with your co-workers, and even though it is short, the relationships you build with your patients.

This nurse's insight raises several issues. Note how Irma does not mention a tragic experience or a loss but focuses on the stress of a busy day at work. The camaraderie results from coping with overburdening assignments, harkening back to Suzanne Gordon's depiction of nursing.

However, Gordon rarely touched on the fun of nursing. Often, it may be easier to focus on the negative aspects of a topic, especially work. She sees her work as sometimes "really fun" and also rewarding. Calling out the relationships at work as rewarding is reminiscent of the work of Carol Gilligan. Gilligan's work on the psychological development of women, starting with *In A Different Voice* and the decades of research that followed, posited that women see the world differently than men, for a more relational viewpoint (1993). Irma's words about her colleagues illustrate something deeper about the relational orientation of nursing and the essence of care-work.

Maryanne looked back on her decade working in OB, explaining the intensity and uniqueness. She said, "It was the most congealed, family, take-care of each other place. It was phenomenal. If I could not take care of something, someone else would have my back. I called it the 'Golden Egg.' To this day, I still say it was incredible. I wish everyone could have that experience. There would be more nurses and better nurses." Instead of claiming that nurses eat their young, she reports her relationships in OB were "The Golden Egg," a precious and rare occurrence in a workplace, a tight-knit family of support. This relational aspect of a career, with the social support and shared understanding, cannot be minimized. While OB nurses may

sometimes express irritation with their “catty” co-workers, being part of a sisterhood is a significant component of their occupational culture.

Insider language and legends: Never say “Quiet” & Never trust a pregnant woman

One way the occupational culture of OB RNs is shared is through insider language and legends. When asked to share insider languages, phrases and superstitions, the participants were eager to discuss this topic. There were a lot of overlapping superstitions, and some were less universal. With a shared language and shared folklores, OB nurses of differing backgrounds thus shared a common culture. While RNs are trained in the “hard sciences” and have a scientific knowledge base of the physiological processes of the body, there was little disbelief or skepticism discussed around these legends based in superstition. A nurse who discussed at length the need for evidenced-based nursing practice in birth also actually knocked on wood when she said, “Never say ‘quiet.’” The shared language further binds the occupation and glossary of terms has been provided. The occupational lingo becomes a shorthand for communication and signifies insider status.

Three beliefs were nearly universal. The first was regarding the full moon. Multiple participants even told me that studies had been done, and it was true: More women come in on labor during a full moon. A full moon will mean a crazy night at work. There was not much scientific rationale described behind this widely held superstition, although one nurse said she heard it had to do with the tides and the gravitational pull on the bag of waters.

The second belief was similar to the full moon, that more women come into the hospital in labor when there is a storm. According to the theory, a storm or rain can cause changes in barometric pressure, thus causing the bag of waters to break. Some participants professed to truly

believe this as a scientific fact. One nurse told me, “The full moon, that is legit.” Another nurse, Sara said, “It really is true that it gets crazy on a full moon, or if it is raining, that everyone's water breaks.” These types of comments were told matter-of-factly, with no sense of irony or much explanation.

The third widely held belief was around the word “quiet.” There was absolutely no scientific explanation offered for this true superstition. Some of the participants were hesitant to even say the word out loud in their interview, opting to say the stand-in phrase “the q-word.” Saying quiet out loud or even talking about not being busy was seen as a curse, asking the universe for birth work-related chaos. One nurse told me a story about her conversion to this rule. She previously did not believe in the powerful curse of saying “quiet” out loud, and she would tempt fate by saying it to provoke distress in her co-workers, in her amusement at their silly superstition. However, she repeatedly had unfortunate events and busy shifts subsequent to her use of the q-word. She had since changed her mind and will no longer say it aloud, to the relief of her fellow nurses.

The power of the q-word to unleash a curse extends beyond nurses. Nurses also expressed anger when a patient used the word. OB nurse Janet explained, “Like a patient comes into triage saying, ‘Oh its quiet.’ I want to punch them.” Another nurse Candace told of a new volunteer on the unit that used the word quiet. The volunteer was surprised at the reaction of the nurses and was later apologizing for her misstep when several patients came in labor and there was an emergency. These stories demonstrate the strength of the taboo against saying quiet aloud.

A similar taboo word is “slow.” Several nurses expressed a prohibition against describing the shift as slow. As previously discussed, staffing ratios and nurse assignments in OB are

contested topics, along with on-call shifts and frequent cancellations. Due to the sheer unpredictable nature of labor and birth, frequent ebbs and flows of the volume and acuity of patients happen, which can greatly impact the workload on individual nurses and the team as a whole. So, while sometimes an OB unit may have a low census, the nurses are hesitant to call the situation “slow.” Tonya summarizes this, saying, “Quiet or slow- don't say it. If a staff member is on call, they jinx us if they ask if it is slow.” They reported using other phrases, like “We are okay” or sharing the low number of patients without using the slow word.

Another belief shared, although not entirely universally, was the taboo of erasing the board. In many OB units, there is a white board where current patients are listed, and their status is updated. In other units, this is electronic. However, there is a belief that the board should not be erased. If there is no one in labor, the last patient to deliver remains on the board, often crossed out or written “DELIVERED” through the information, but not erased until a new laboring patient arrives. In the electronic version, a patient may be kept on the board with status changed, yet not moved from this list until it can be replaced. This practice was not as common among the nurses at the much larger, high-volume hospitals, but it was reported at several Chicagoland hospitals and a few others outside the area. This practice, to “never erase the board,” is shared amongst nurses and doctors. Although some do not believe it is a curse, no one was willing to erase the board because that likely would mean taking the blame from their team for the next negative outcome or emergency. One nurse told a cautionary tale of an arrogant resident who erased the board, only to have the worst night of his career, including an emergency hysterectomy and multiple “crash” sections.

One nurse described how certain rooms are considered cursed and nurse do not want their patients assigned to that room, which is a phenomenon I had heard of as well. Tonya told me,

“Like right now, room ten is cursed.” Also, the theory of “the black cloud” was mentioned, that some people bring bad luck. “A black cloud” is not necessarily a bad nurse, but is frequently in difficult situations, negative outcomes and busy shifts. One nurse, Josefina, shared a unique black cloud experience, that fellow nurse swears her earrings shaped like gummy bears are bad luck. Whenever her co-worker wears her gummi bear earrings, it will be a bad night at work, supposedly.

Some other legends were discussed, including the belief that redheads tend to bleed more. Another one mentioned was if a patient brings in a roller bag or a pillow, they will be high-maintenance and difficult. Halloween is purported to be busy and supposedly bad things happen in threes. When a nurse sits down to eat, she will inevitably be called by her patient or a baby will decel. Also, when there is a party or holiday meal planned, the busload of pregnant ladies shows up to disrupt, according to folklore. When a patient brings a written birth plan, they are purportedly dooming themselves to a cesarean section. This was actually studied and is not true (Yang et al 2014), but the belief persists.

Here, Jana shares a particularly graphic anecdote, “If you come in with a birth plan, you will have a cesarean section. Sometimes, we would draw a knife with the blood dripping off it! One of the residents, that was his thing. He would take bets on when the section would be.” While this quotation could certainly be further examined for bias against natural birth in hospitalized setting, it demonstrates more than the cavalier attitude towards birth plans. It shows how deeply engrained this belief is, that the existence of a written birth plan leads to graphic, flippant cartoons of violence and even gambling! One nurse joked that their team would say the indication for a c-section, which is required operating room documentation, was having a birth plan.

A participant who currently worked as a midwife talked about this bias against natural birth and violent undertones in language used in birth. Lynda reported, “It drives me crazy when someone asks me, ‘Are you going to cut her?’ Like its West Side Story and I’ve got a knife? The language is just so violent. I will say, ‘Maybe a surgical birthing option should be discussed.’ Not like casually cutting women.” The use of the verb “cut” is commonly used. For example, a seasoned nurse reported, “Lots of times, if the patient is under 5 feet, we are assuming they are going to get cut.” The assumption is a shorter woman will have a smaller pelvis and less room to deliver vaginally. In addition to “cut,” another phrase mentioned, although less commonly used is, “She is getting a zipper” to mean a patient is having a c-section. “Push the pit” or “Pit to commit” is the shorthand to explain an aggressive augmentation with Pitocin to speed labor along. There are also ideas about different cultures birthing abilities, but this topic will be addressed separately.

The phrase, “Never trust a pregnant woman” is employed to signify that there is so much unpredictability with birth and to never let your guard down. Related, but more specific, is the phrase to “Never trust a multip,” meaning a multiparous woman. Women who have previously given birth tend to have shorter labors and may deliver quickly, so it is necessary to be prepared. The wariness of multips is a subset of the larger shared belief regarding the randomness of labor and complications. However, by instilling a sense of mistrust and advising to beware of unknown multitude of factors, the phrase “Never trust a pregnant woman” provides a conceptual bridge to the next major finding of the research, the importance of safety in the OB RNs’ work.

Safety Imperative

Within the culture of OB RNs, the duty of providing safe care was embedded throughout conversations as a moral imperative. Fear of litigation was an undercurrent, but the mantra from

the OB nurses was “healthy mom, healthy baby.” The nurses saw guaranteeing a safe birth as the purpose of their work. This can be thought of in terms of Hughes’ occupational mandate. The theme of safe care was consistently discussed and referred to as an obvious tenant of their work. One nurse summed this attitude up, saying, “When I walk into work, my number one job is the health and safety of a mom and a fetus. My number one goal is a healthy mom and healthy baby.” Another nurse described her “role is to safely guide someone through their labor and delivery, to teach them as they need to be taught.” The educational aspect of OB nursing was included as a component of the safety imperative.

This risk of traumatic birth underlies the whole medicalized model of birth. One of the key components of post-traumatic stress syndrome is a heightened arousal, a sort of jumpiness that doesn’t necessarily go away. When advocates of the midwifery model, like Barbara Katz Rothman (2007), Hausman (2005) and Robbie Floyd Davis, argue against the underlying risk avoidance at the heart of the medical model of birth, there is a disconnect. Labor and delivery nurses have experienced their patients’ traumatic births and will likely not forget them. These are the cases that they replay in their minds, feel guilty about or fear will happen again. Like the respondents in Beck and Gable’s 2012 study, which found that nearly two thirds of OB nurses have a memory of a traumatic birth that is problematic, the OB RNs interviewed in this project reported similar experiences.

Let’s apply the results of this study to the example of physician-ordered bedrest after rupture of membranes. When a laboring patient’s water is broken, sometimes the patient is ordered to be on bedrest by the MD to prevent cord prolapse, when the fetus’ head compresses the umbilical cord against the cervix and cuts off flow of oxygen. A natural birth advocate and the midwifery model may bemoan the enforced confinement of a woman in labor, arguing that

restriction of movement stalls labor progress and causes more pain. While this may be clinically true, the risk of cord prolapse must be weighed. Despite knowing the statistical unlikeliness of a cord prolapse, the OB nurse can recall, with startling clarity, that very situation. She may think of the helplessness, the urgency and the overall intensity of a prolapsed cord, what it felt like to rush back to the OR with her hand still inside of her patient, attempting to relieve pressure from the cord by holding the baby's head away from the cervix, riding crouched on top in the bed being wheeled rapidly down the hall, unable to move until the baby was surgically removed, hoping the infant was not suffering permanent damage from lack of oxygen from cord compression. The need to support natural movement in labor could fall secondary to the shadowy danger of that horrible situation.

Medicalized birth is designed around mitigating risk. This sense of risk creates the safety imperative around medicalized birth that the OB nurses interviewed wholeheartedly endorsed and embraced. When safety is contrasted with freedom, the possibility of harm trumps the possibility of empowerment. In the cultural conflict around natural versus medicalized birth, the safety imperative has been indoctrinated into OB nursing culture, leaving the discourse of the midwifery model in question. If birth is a normal physiological process, how can it be so dangerous?

The medical model of labor is designed around risk and requires weighing costs and benefits. If those in the medical world are trained to see each pregnancy in terms of risk coupled with the random unpredictable emergency, how could they ethically ignore those risks? The question sometimes boils down to weighing the mere possibility of a lifetime of cognitive and functional impairment related to birth trauma versus the possibility of not feeling empowered. The paternalistic attitude of the medical model does include the sense of protection.

This safety imperative was seen as more important than patient autonomy and empathy for some, like the nurse who said the following:

It makes me angry when it becomes more about mom's experience and controlling it and less about getting your baby there safely. I don't care how it's done- medicine, pain control, c-section, whatever. The end goal is to have a healthy baby, not to have a birth experience story to tell your mom group.

This nurse encapsulates the dismissal of the critiques of medicalization of birth in the name of safety. She critiques the desired experience of the woman giving birth as selfish and trivial, contrasting the primary purpose to produce a healthy baby. Note how she does not explicitly discuss the health of the mother in this quotation but focuses on the production of the baby. Here, this nurse can be understood as expressing her frustration at the midwifery model, in the name of safety. The patient's experience and the concept of empowering birthing women by supporting a normal physiological process seems inconsequential when weighed with safety. The safety imperative is the guiding principal for this nurse. The importance of the cultural narrative "I don't care how it's done" and also personal narrative about birth- a "story to tell your mom group," are dismissed. According to this nurse the purpose of birth is "a healthy baby" as the product of delivery, with the birthing process of reproduction as "whatever" as long as it is safe.

Cultural Competence or Discrimination?

Nurses often professed to provide quality care to all patients, regardless of their social status. Often, the participants were hesitant to describe their behavior as biased, although a few were open. One nurse adeptly described treating patients differently was about walking a fine line between cultural competency and discrimination. Race was frequently sidestepped in

conversation, but culture and ethnicity were far more fertile ground for discussion. Sabrina said, “I have not faced discrimination on the job, because I am an educated, white woman. Well, let me think. I may have had my knowledge or expertise called into question when I first started because of my young age.” She acknowledges her privileged status and reaches to understand how it might feel by looking to her age. Her frankness was unique. Most of the participants who were white women responded to question about facing discrimination at work with a simple “no.”

Nurse Kathy told a story about a patient who reported to management about being treated poorly by nurses due to perceived racial bias. The nurse was open in her opinion about the situation, comparing her class bias as similar to a racial bias, and suggesting that most overtly racially prejudiced nurses would self-select to work in a different “whiter” place. This story is told below:

Supposedly, the people caring for this couple were discriminating and made derogatory, whatever, statements. I didn't see that happen. I said, “I don't see that and then it was about like race and religion and different kind of things.” and I said, “why would someone even want to work in a place, you know where you are at, you know the demographic that comes to this hospital why would you even apply?”

This manager, who was black, said, “You wouldn't believe what people would do.” Honestly, I will respectfully disagree because, to me, that makes no sense whatsoever. And if you did come to work here and didn't know what you were getting yourself into, those people are going to leave. And I don't even know that it's a race thing, as much as it might be they're just not used to the demographic. Just like I don't want to be at some

hoity-toity place. I don't hate rich people. I just don't really relate well to them, you know?

For Kathy, a Caucasian nurse, the distinction between “relating” to the patient and discriminating behavior is based in hate. However, it is quite possible to conceive that being unable to “really relate well” is treating patients differently and can be perceived as biased behavior. One nurse described why she left her job as an OB RN and switched fields, her own self-selection out of a hospital with a minority patient population.

This is going to sound weird, the socioeconomics of those patients. It was so sad, so sad to what those babies were going home to. I would look around the neighborhood when I was leaving in the morning, thinking, ‘How do we change this? What are those kids going home to? How do we fix that? Look at the schools. How do we fix that?’

And I thought, this is too big. And too sad. I can't fix it. It is too big for me. But I cannot be a part of it anymore. It was just too sad for me. Just the poverty. The poverty. What do these kids have? And what future did these kids have? I would look at parents, I looked at the neighborhood they were from, what they were going through, ah, it was just heart-wrenching. I couldn't do it. Some of the patients would be on drugs, some of it was too big. But I liked the camaraderie with the nurses- it was good there.

For this nurse, the class of her patients and the poverty was overwhelming. While she does not mention race, she does focus on the reproduction of social problems and the nurses' role. With her education and privileged status, she has the luxury of not having to live or work in such environments. Grappling with the harsh realities of inequality was difficult, although she does point to the sisterhood theme, as a positive factor in her work as an OB RN. Touching on another

problem, she mentions patients on drugs, which also was described as problematic for other participants. Suspension of judgement for pregnant patients who used illegal substances was mentioned several times, as well as caring for seriously mental ill pregnant women.

In confessional-style, some nurses reported treating patients differently based on social factors. Another OB RN, Tonya, admittedly noticed differences in patients and attempted to describe her interactions as follows:

My hospital is in what you might call the ghetto. It is not a clean area, it is not rich. A lot of times, they are attention-seeking patients, from doctors, nurses and their families.

There are times they will roll in, in an ambulance, into the hospital at 3 AM because they can't find their baby-daddy. They are taking up resources and a bed in my triage and that is frustrating.

This same nurse had earlier described working with depleted resources and intense budgetary restraints. Tonya's description does sound lacking in compassion and full of implicit racial bias. She does not outright discuss the race or ethnicity of her patients, but she employs coded language to signify she is speaking about non-white patients, like "baby-daddy," "roll in" and "ghetto." Her frustrations and crassness are more likely intensified by being a sense of being overworked and lacking resources. Note how she uses the signifier "my" triage, revealing how she has a sense of ownership over her work area.

In the following passage, Tonya honestly speaks of her perceptions of difference in patients that require different responses from the nurse:

There is definitely a difference in patients. There is so many not-PC things. Having a teenage patient is different. They are an absolute child, the way they react to pain, the

way they react to being told no when that's not the best for their baby. It's hard because they act very childish. If you have a patient who this is their 3rd baby, it's not her first rodeo. She knows what she wants, what to expect, comes in at 6 cm and wants to walk. All the sudden she is complete and pushes 2 times. That is the most perfect labor and delivery. That is my favorite patient. There is a difference. If a teenager is acting a fool and you can't calm her down to get it together, to explain what is going on, yeah, she is going to be treated differently. If she is screaming and hysterical, you may find yourself raising your voice to be heard

Her comments contain several items that were mentioned by other nurse participants. Providing care for an adult woman in comparison to a teenager can require a targeted approach, as their developmental needs, especially in childbirth, are different. For Tonya, the lack of respect for her authority and lack of coping skills from teen-aged patients provokes frustration and irritation. When a teen mother-to-be is "acting a fool," Tonya tells us she has trouble calming her down, resulting in raising her voice. Once again, she does not outright use racial descriptors, but it does seem she could be using coded language to imply her bias. Other nurses reported finding teenage patients in labor difficult for similar reasons.

The Polish Pelvis

Tonya's description of her favorite patient was mirrored in other interviews and does not use racial or cultural descriptors, rather biological factors in labor. There persists a cultural expectation among OB RNs that women of Hispanic origin deal with pain better and tend to have faster labors. This myth was touched upon in the previous section, but also echoes Zbrowski's

1950s essay on perceptions of pain amongst different ethnic groups. Candace said her favorite patient was, “a Hispanic multip who comes in and just delivers.” Jody said in her interview,

Tread lightly here, but certain cultures, I think, have demonstrated different birthing processes or abilities. You know? Like the ‘Polish Pelvis?’ Or some of our Hispanic patients know exactly what they are doing during and after birth without much guidance. So not that we are making those up- there is something to it.

Jody, another Caucasian RN, also professed to enjoy “Polish or Hispanic multip quick deliveries” and applies takes her understanding of how different cultures have different birthing abilities. She does acknowledge this is a dangerous conversation and she does not wholeheartedly subscribe to those beliefs, when she uses the qualifier “tread lightly here, but...” The “Polish pelvis” as a term that popped up a few times, with a shared understanding that Polish women’s bodies were shaped better for quicker, smoother vaginal births. There is no hard scientific evidence to this, but rather an ethnic folklore component based in a “commonsense” assumption that Polish women are taller in general and thus have wider hips. A more culturally-based explanation is childbirth in Poland and subsequent immigrant Polish culture occurs in more midwife-type of paradigm where birth is conceived as a normal physiological process rather than a medical, risky endeavor. This ethnic “otherness” attributing naturally-occurring, innate child- birthing and mothering skills is framed by the participant in a flattering, appreciative manner, but could be problematic nonetheless. Assuming a Polish patient will have a simple vaginally delivery or a Hispanic patient will just know what to do post-delivery can provide a gap in care, education and preparation that could negatively impact patients, infants and even outcomes.

Take the words of another nurse, who makes similar assumptions, “Some patients are easier than others because of the culture. Some are more sensitive to pain. Indian women are more sensitive, I get. Polish women- they seem very strong. It’s the culture- how they were brought up, I believe.” When Janet, a self-described “half-Mexican” nurse was discussing the same issue, she repeatedly said the response to labor and pain were entirely culturally constructed.

It is just culture. It is in their culture. Indian women expect childbirth to be painful, same with Middle Eastern women. It is their chance to get babied and taken care of, in their culture. Mexicans grow up watching everyone around them have babies and it is no big deal, just part of life. So, having a baby is not something Mexicans have a lot of questions about, because they have been around it in their culture. Polish people are similar. It is just all from their culture.

These cultural and ethnic ideas around birth and pain were sometimes dependent on the demographics of the patient population where a nurse worked. When a nurse explained how she had worked in an area with lots of patients from China, she said, “ You cannot trust a Chinese patient. She will sit there all quiet, never move, complain or moan. All of the sudden there is a baby. Chinese do not make any noise. So, if one comes into L&D, be ready to deliver.” Nurse Josefina discussed some of her OB work in other countries, discussing cultural differences. In the Philippines, she spoke of the difference in care, the frequencies of homebirths, and alluded to the spectrum of US medical care as “too much too soon” and back in the Philippines as sometimes “too little too late” (Miller et al). TLTL in the Philippines was tempered with different cultural expectations regarding risk and childbirth, occurring without the litigious environment and expectation of safety of the TMTS American birth culture. Another nurse also shared a similar

idea, contrasting the Philippines and US in a parallel matter, explaining, “At home, homebirth and natural birth are normal. Sure, it is risky, but what choice do we have? We are used to it and it does not seem scary. But here, no. I do not support home birth. Not in the States.” Her belief in the power of cultural forces extend even to risk.

Nurse-turned midwife Lynda felt patients were treated differently based on social factors. She said, “Yes, absolutely, 100% . I think that people who come in with, uh, a birth plan or whatever, they are just doomed. They are just doomed. They are going to be laughed at behind the scenes. I think people automatically get pigeon-holed whether they have private or public insurance.” Her insider status as an OB RN has shown her the lack of respect for natural birth practices behind the scenes on the L&D floor. Despite her pronounced commitment to natural childbirth, she also understands the environment that has ridiculed the birth plan as a concept. Also, she brings up insurance status as a social factor, bringing in how health policy can affect personal care.

Cultural Restraints in Nursing Care

In contrast, Josefina spoke of her time working in OB in the Middle East, describing the cultural and religious restraints of her work there.

In the Middle East, women cannot be in the same room with a man, even a doctor is frowned on. I have seen some crazy things, delivered many babies and done so much that a nurse here does not do. Really. There was only a doctor in a terrible emergency, and sometimes not even then. I saw many bad outcomes that would not happen here. But there, there is a belief that whatever happens, it is the will of Allah. So, if a baby dies or has brain damage or a mom bleeds to death, that was unavoidable. It is very different to

work there. If you think a doctor is wrong over there, as a nurse, there is nothing you can do.

While some nurses had an overall understanding of the role of culture in providing obstetrical nursing care, a broader view was influenced by global experiences. For Josefina, she understood the conception of the major differences of cultural practice and role of risk in birth. Her perception of constriction of gender and medical hierarchy in a blatantly patriarchal culture serve as backdrop to the less obvious tendencies in the US. By looking at the religious aspect of culture, she adds another layer to her observations.

Language was another factor. One nurse explained, “We have a lot of strictly Spanish speaking patients and that is complicated. We can get an interpreter on the line, but there is a lot of pointing and head nodding. You cannot delay care waiting for an interpreter. So that is different. It is not disrespectful.” By acknowledging the real gap in care with a language barrier, this nurse points out this discriminatory care is not intentional yet is still not equal. The lack of live interpreters for patients and the use of phone interpreters is complicated and time-consuming for nurses, especially in complex, rapidly-paced situations. In the following passage, Annette details how this affects patients and nursing care alike.

If you don't speak English, even if it is not your first language, -there is such a rush-rush culture in health care- your care is probably not as good. People don't use translators when they should, patients don't know to request them. And it is awkward. It is not conducive to the environment in labor and delivery to have a translator on the phone. It doesn't work really. I think that happens. It is hard.

Here, she points out a major flaw in the health care system, that technically is legally mandated, yet is not strictly practiced. Translators are required to be offered in healthcare free of charge, but often are not. While there may be a kernel of truth in blaming a lazy nurse, there is more to the problem- often a sense of futility with the cumbersome phone conversations or spotty iPad translator service that is a poor substitute for in-person discussion in a shared language.

One nurse, Sara, went as far as to suggest that non-English speaking patients were more likely to have episiotomies, forceps or vacuum-assisted births, as they could not be properly coached in labor or were unable to object. While this may not be empirically researched, she felt this was commonly practiced behavior among some physicians. Irma, a native Spanish speaker, reported she felt it was her duty to seek out patients she could provide Spanish language care, hoping to address some of the gaps in care, make these patients feel more comfortable and make sure their needs were addressed. She adamantly maintained, as many other nurses agreed, that patients who did not speak English were not receiving the same level of quality care, regardless of the cause.

A different nurse Jana described her experiences within the current political context. She was acutely aware of the patient's perception of her and purportedly appreciated her assumptions being challenged.

Certain cultures disrespect women. Certain people of certain education statuses or races assume I am going to discriminate and have been pleasantly surprised when I haven't. They have a wall up, which makes me very sad. Especially since our current election, I have sensed people bracing themselves. Because I am a white, educated, middle-class person that who very well could have been someone who wanted Trump as president. That makes me sad.

Additionally, the best patients were frequently the ones deemed grateful and kind, and likely received better care. Luz said she “did not see color but I give more attention if they are nice to me.” On discrimination, Luz insisted, “I don’t pay attention, I don’t see it. I just don’t want to see it. I take the best care I can of every patient.” Here, she admits that she willfully chooses not to address discrimination. Nurse Lillian professed quality of care was proven to be related to kindness in patients.

There have actually been studies that show if people are aggressive or appreciative, people who are unkind and treat you poorly, you are less likely to want to be around them. It's human nature. So, the people who treat me like that, I find myself spending less time with them, spending less time in the room. In general, if you are kind, and receptive, respectful, your care is going to be better.

Nurse Luz had a different viewpoint on preferential treatment. She reported noticing that occasionally patients are treated better based on their social status and even are assigned a specific nurse. She says, “Right now, we have a room that is blocked. Because there is someone that is coming, that is a sports person. And the nurse is blocked. That is not right.” By reserving a particular nice room for a VIP and pre-assigning a noted “young, white, pretty nurse,” Luz maintained that despite her decades of experience, the appearance of the nurse was more important for management to give a good impression, rather than the best care. The race of the “sports person” was not described, but the race of the nurse was.

Candace professed a sense of cultural relativism and openness to diversity, with genuine curiosity and understanding. She explained her way of seeing differences in patients as within a cultural context. She said, “

I try not judge or make assumptions. I love hearing about where people are from. At my hospital, there are people from all over the world, and lots of Muslim patients. I try to remember that my life may seem foreign and strange to them, a single woman in her thirties with no children who lives alone, not even with her parents. Wearing a head scarf or letting my mother-in-law name my baby may not seem right to me, but I realize that my life probably doesn't make sense to them. Plus, it is kind of fun to talk about what is different here. Like I was explaining Halloween to a patient last week because she didn't understand why there were ghost and witch decorations. She told me in her country, that is like devil-worship.

This nurse has found a way to walk that fine line between cultural competence and discrimination, by accepting her patient's worldview and being supportive in their exposure to a new culture. She shows astute awareness of other's perception of her and her willingness to engage in sincere conversation about culture with patients extends beyond her OB knowledge, as a sort of a general cultural ambassador.

Occupational Role Ambiguity

Lack of role clarity was a source of frustration, including doctors expecting nurses to be subservient helpers and patients seeing the nurse as a servant. Nurses felt their role was not always understood by others. Nurse Sara said, "My grandma asked me, 'What do you DO as a nurse?' It is really hard to answer. I feel like we do a million things and it is so hard to explain. It is not what happens on TV. Childbirth has such a taboo, and we have the insider information." The central role of the OB nurse in the birth process was brought up and a nurse, Agnes, explained it like this, "In OB, you need the nurse. In labor, she is there more. People are surprised at how much their nurse does and how much they need her." Bemoaning the occasional

expectation of subservience from nurses that detracted from work, a participant said, “We wear many hats and some I don't agree with wearing. (laugh). We are a patient advocate, a patient educator, a strip reader, documentation checker and, you know, there are so many things we do. And on top of all that, we are unfortunately waitresses.”

A common sentiment among the OB nurses interviewed was frustration with being treated as servants. Often, they said some people did not understand the role of the nurse, had unrealistic expectations of the nurse or were very demanding. This quotation encapsulates this is perfectly: “I have definitely had some patients think that I am their slave, and that makes it hard to be nice.”

The problem of nursing is that it is not well-defined. Some nurses call it a calling, but for others it is just a job. “Nurse” is often part of an identity, with the work impacting ways of thinking and being in the world. Often, nurses see their work as a profession, sometimes a science. Others see it as a natural ability, but some see it a learned skill set. Sabrina said in her interview that she really “thought of nursing as an art, blending science and care.”

Most people have a respect for nurses, but do not exactly understand what the role of a nurse is. Nurses have varied understanding of their role, but overall see their work as first keeping patients safe and secondly healthy. Nurses understand their work, but there is a great deal of variation in how their work is seen. This lack of clarity of the nurse's role can lead to dissatisfaction and frustration. In the literature, this notion appears, in Disch's article rallying to “Make the Glue Red” and make visible to work of nursing (2000), as well as in Allen's book *The Invisible Work of Nursing* (2015).

Suzanne summarized her thoughts on patient's misconceptions of the nurse's role like this, "They just think that we are the doctor's secretary, that we are writing everything down. And that the doctor is making all the decisions and all the calls. And I am sure they think we are talking to them more than we are. 'Cuz we really aren't." She clearly understands her job as more autonomous. Lillian reported another refrain, "People tell me all the time, 'I had no idea that my doctor was not there the whole time. That they just come at the end and the nurse is the one with you.'" Additional nurses shared this sentiment, that patients frequently were surprised at the lack of presence of the doctor until delivery,

The following story told by nurse Jody illustrates this lack of role clarity as well,

We were in the bathroom and she couldn't bend over. So, I was putting the pad on her and she made some comment, and I know she meant well, she said, "Oh my gosh. It takes a special person to do that." Like she meant to put a pad on her bottom. You know, you are sitting there like, oh, I don't know how to put a term on it. But it is a weird social interaction. I think they belittle your role, like you are there to wipe them up and clean them up. They don't get that it runs deeper than that. That you are running the strip, that you are the eyes between the doctor and the patient.

The term "eyes on the patient" and "watching the strip" encompass the thematic safety imperative, within a sort of Foucauldian surveillance model, as described by Allen (1997). Jody realized her patient had a very different perception of nurse's work and saw it primarily in terms of "doing dirty work" instead of the entirety of her role. To recognize the occupational role ambiguity of nursing, Jody illustrated the point with a poignant story, describing how a patient saw her work with misguided pity, rather than a true understanding of the capacity of the nursing role.

Medical Dominance and Nursing

Occupational role ambiguity extends beyond nurse/patient relationships. As the hierarchal culture of medical dominance shifts to team-based models of care, the relationships between doctors and nurses becomes more nuanced. This concept of “negotiated order” was applied to the nurse-doctor relationship in the literature by Allen (1997), a set of fluctuating, socially created borders of work domains. With fluctuations can come uncertainty. Nurse Raquel offers this assessment “The more I listen to doctors talk, the more I realize that they don't know what that is, what the nurse does. Some think you are their assistant and others aren't sure how to use nurses effectively.” Seasoned nurse Luz depicted the changes she experienced in the nurse/doctor relationship over time, saying “In the olden days, the doctor was like God. Nurses held the chart. Now we have a little power.”

Conflicts about the plan of care emerged as problematic, particularly when a nurse's clinical judgement was subordinated to the doctor. Nurses often professed an ability “to deal with doctors”, describing an understanding of how to work with physicians, but some found the occupational inequality troubling. One nurse pointed to the historical hierarchy and lasting effects of nursing subordination replicated through education and occupational culture.

I think the way physicians are trained sometimes is outdated, with an aspect of, “we write the orders, we are god, not a team.” It is the physician's job to educate her to understand why. And you, as the doctor, are falling short if she doesn't understand. I think there is a lot of blame placed on nursing. I think the medical world need to update to a team. I think nurses need to be taught to be empowered and to see us as more than support staff just following orders.

This participant thinks her role as the nurse is devalued and struggles with dominance of medicine. Some of the implicit power dynamic is highlighted by emphasizing the internal language of the hospital world. Within medicine, there is a language of dominance with giving orders. Within nursing, the linguistics belie the subordinate position, with terms like support staff and the need to follow orders, removing autonomy. In her view, the burden of changing the status quo should be shared by both occupational groups and reflected in the professional education of doctors and nurses.

Another nurse contrasted two types of doctors and addressed the problematic communication of doctors not behaving professionally, as lamented by Suzanne Gordon in *Nursing Against the Odds*. This participant explains how she has to cope with physician's anger in the course of performing her work, voicing the unfairness of bearing the brunt of a doctor's frustration. She explains,

I have dealt with one physician that will cuss out nurses and is rude to patients. Some doctors get mad when you call them in the middle of the night, and I just want to be like, "You know, you chose this profession. You knew you would have to be on call. " It is frustrating. And then there are some doctors who are ridiculously kind, who will call and check, saying, " So what did you decide to do?" It makes everything easier.

Offering this comparison shows how the work of the nurse is complicated by having to deal with the hostile attitudes of some physicians.

Nurses shared how their opinions were disregarded by patients, management and providers, leading to a sense of disenchantment. Often, nurses shared stories how their nursing experience was not valued as legitimate despite having an extensive knowledge about birth,

medicine and obstetrical practices. A participant said, “There is a ‘Oh, you are just a nurse’ kind of a thing. Not all physicians, I can't speak for everybody, but sometimes your professional opinion, even if you have been doing it longer, doesn't quite matter. That can be frustrating, especially when you are trying to advocate for your patient. “

This shifting landscape relates back to a point of Suzanne Gordon, that nurses feel they hold all of the responsibility and none of the power (2005, p. 72). By lacking decision-making capacity, nurse may retain a sense of absolution from the burden of negative outcomes. This relates back to a point raised in an article comparing physicians and nursing viewpoints (Uden 1992). A physician remarked how nurses wanted to claim rights to “connection” to patients and retain the right to criticize yet were not willing to take responsibility for decisions. This contradiction may hold some validity. Several OB nurses explained they did not want to be midwives or doctors, that they preferred to leave the decision-making and stress to the physicians. With the abdication of the responsibility of decision-making, perhaps nurses receive a version of absolution from negative outcomes. However, the sense of duty to protect patients, as in the safety imperative, may be mediated somewhat by the lack of autonomy. With the ability or authority to make decisions, comes the burden of responsibility for the outcome.

Emotional Labor

Performance

Some of the participants were familiar with the concept of emotional labor, as popularized by Hoshchild (2003). Once prompted, they could describe how they controlled their emotions at work, yet often found the practice unremarkable. Occasionally, there was a different perspective, which was more of a Goffman-style of performance, a presentation of the nursing

self “on-stage” with patients in contrast to the back-stage “break room” authentic self (Goffman 1959). The following quotation is typical of the responses received:

Personally, if it is a difficult patient, most people are good at being professional in the room. Like my patient with the Bradley plan the other day, I had to chuckle. She had her birth plan, like 11 copies, on lavender paper with essential oils. I mean, I might have been that patient if the tables were turned. But in the board room, sometimes it is laughing or fuming. I definitely have made fun of my patients in the board room. But it is coping. In the patient room, I give all my hope and encouragement. The energy matters.

Another nurse, Sara, summed it up similarly, like this: “With a difficult patient, you are nice to their face, but in the board room you can let off a little steam.” There is the split of performance, the strategic presentation that incorporates emotion management.

I would like to think I am pretty honest with my patients in general. I have much more patience with them in the room than I do outside of the room. You have to. To them, I want to appear like the most patient person in the world. The other day, I had a patient, like for 3 days she refused to get out of bed. She refused to have her Foley dc'd. I gave her her medicine like I was giving her the first Holy Communion. Did she know she was making me crazy? No. Sometimes you decompress outside of the room. Sometimes. I think we compliment the patients as much as we vent about them outside the room. Like I might say, ‘She is doing awesome,’ or ‘She is absolutely crazy.’ But as far as their care, there's not anything I am withholding or hiding from them.

The participants had internalized the emotional labor they routinely performed as an important nursing function that becomes ingrained. The backstage discussions about patients can also be

understood Hughes' terms of guilty knowledge and license (2009, p.289). OB RNs violate typical social boundaries in the course of providing care for their patients and know intimate information and witness behavior under extreme circumstances, which affords them Hughes' concept of guilty knowledge. With that guilty knowledge, the OB RN display a sense of license to discuss their authentic reactions in private with peers, rather than maintain clinical detachment and unwavering support with patients.

Here a nurse positively describes her emotional work, "I feel like the longer I have worked, the more I connect to people. It's amazing how women in that situation need other women. Especially after having babies of my own. It feels easier to cultivate that." This reinforces nurses' ideological narrative claim on "connection," as described by Uden (1992). Another nurse Raquel expressed a comparable awakening, saying "When I became a mother, I understood how an OB patient feels, and I was more compassionate towards them." This was not a universal phenomenon, as Janet harshly tells it,

When I was pregnant the first time, I thought I would be more compassionate after labor since I will know what they are feeling. Especially since my second baby, I was like, 'What!?' When a patient calls me for something silly, I'm like, "I was never that bad." And that is terrible. Because everyone's labor is different. And after having two very different labor situations personally made me realize that different labors can be more painful and feel different. But I am also like, 'Quit being a baby.'

While OB RNs conceptualized the management of emotions at work as straining, it was also described as a vital part of the job, a learned skill to promote the patient's well-being. The following quotation describes this perception:

With the patient, I always try to be positive, to be encouraging. I don't always feel those things, right? It is so important to the patient that you believe in them. You are really that last line- you are the cheerleader. You are going to think that I believe in you, even if I don't. Sometimes that is tiring, especially if you don't really like them or connect with them. That can be really tiring. You kind of have to be on your 'A game' and on, all the time. It can be exhausting, but that is my role. And it can be hard.

This reflects the ambiguous nature of carework as described by Bullock and Waugh (2004), as simultaneously a source of pride and strain.

Haunted by loss

Coping with loss for the OB RN is a unique situation, as a majority of outcomes are positive. A newer nurse, with about a year of experience, shared her difficulty coping with loss at work. She shared a story of caring for a woman with an intrauterine fetal demise (IUID), commonly known as stillbirth.

I don't manage it very well. I don't hide anything very well. I get emotional just thinking about it. I ask myself, 'was there something I could have done to prevent that?' With grief, I think it is hardest with an IUID- that's just so hard, on so many levels. I learned my boyfriend's mom had one and I made the connection. That's gotta be the hardest thing for someone to go through. It's one thing to have a patient go through it, not that you leave it at work, 'cuz you definitely grieve about it, like the following days. There is one I don't think I will ever forget.

In contrast, other nurses, like Tonya, described this part of the work as fulfilling, saying

I love to help people when they are the most vulnerable. 90% of the time it is a very exciting time and I like to experience that along with my patient and their family. The other 10% of the time when it is not a happy occasion, you know, being able to be a resource for my patient and get them all the services they need. It is rewarding honestly.

By sharing an intensely personal story of personal loss that impacted her decision to become a nurse, one participant explained her personal mission to support women undergoing perinatal loss.

My first-born was born with a major birth defect and being immersed in that world; the nurses were just so caring. You know, it just made such an impression. It kind of reawakened a dream. Again, after what happened with my son, I knew that I wanted to be in L&D for those moms who were going home empty-handed. Those moms with multiple miscarriages, with stillbirths. Not the ones who delivered healthy babies. Anyone could do that. But I wanted to be there for the moms like me.

Her desire to become a nurse and to work in OB was described as a calling, but her motivation was far different than the rest of the nurses interviewed, as a way to channel her grief. Most nurses interviewed described having “war stories,” particular cases that they would never forget. The in vivo code for this section, “That was a spicy meatball” arose from a participant telling one of her worst cases of loss she had dealt with, a patient that she thinks of frequently. This case haunts her, likened to heartburn and a sort of mental indigestion that won’t go away. She explained, “It comes back to haunt me- it just pops up in my head all the time. It’s like a spicy meatball. It keeps coming back, making me feel rotten.”

Agnes offered her story of loss, of mental indigestion, below:

Yes, I was just off orientation and I had a uterine rupture. It was the scariest experience of my life. It was really hard. I didn't know if I wanted to be a nurse after that. I saw the uterus after the hysterectomy. It was so intense. Had any more time gone, if we hadn't caught it, we would have lost the mom. I can't remember what I did. I can't even say if I was an effective provider. I don't know. You sort of just go to a different place. You just keep moving forward. And you, I think I look back, that was my first real emergent situation. And all the things I didn't know where they were. I committed it to memory for the next emergency, I remember the anesthesiologist kept asking for thermal blood tubing. Nobody knew where it was. Or even what it was. I know exactly where it is now.

She reports her sense of “going to a different place” and how she knows to “just keep moving forward” in the emergency, and also the impression of coping with inexperience in the face of intensity. This sense of “going into nurse mode” is something other participants described, a sense of timelessness and working through the actions with suspension of emotion, which partially relates to the sense of “flow” in work that was described by Csikszentmihalyi (1990), Zito et al (2015) and Bringsén, et al (2011).

Jana offered her reason for leaving after over a decade in OB as follows, “A couple of really bad things that happened, a couple of mistakes. It made me wake up, and think, do I want to keep doing this? It was a lot of stress to live with. I also looked at some of the older nurses and thought, ‘They seem kind of miserable. Do I want to be a miserable nurse?’” The stress of dealing with trauma, like the post-secondary stress described by Beck and Gable in 2012, was not what Jana wanted in her career.

“Pull up your ‘Big-Girl Pants”

One strategy of coping with emotional situations at work was a similar sentiment described by separate nurses, a type of survivalist self-talk that demonstrates the stresses of constant emotional labor. Let's compare the two stories with the nearly identical in vivo code from nurses across the country.

After a third night on, small things kept ticking me off. And then I had to go into the patient's room and be professional, even though I was just balling my eyes out for ten minutes. I splashed some water on my face, took a couple of deep breaths and pulled up my big-girl panties. Still, that third night I am crying. I have always made a point to not become cold. I think I have changed emotionally reacting to certain situations, but I don't know if its necessarily a good thing. Sometimes it is really hard when you have to do your job and can't really be the support.

Contrast this with this other nurse's tale of emotion management when a disgruntled patient willingly urinated on the floor.

I had to step out for like 2 minutes , clear my head, a few tears ran down my cheek. Well, I said, to myself, 'Suck it up. You can do this. And go back in.' In that moment I had all these emotions, angry, pissed, like wanting to yell, 'You literally peed on my floor. You are 23 years old and you peed on my floor.' There are even nights when you get angry at the charge night, like, "This is my fourth delivery of the night and this other nurse has had one patient the whole night." Like sometimes it is luck of the draw and you get angry. But you have to pull up you big-girl pants and do it.

While emotional labor is internalized as part of performing nursing, that does not mean that it is effortless or without cost. “Pulling up your big-girl pants” is parlance for just dealing with the difficult situation calmly and portraying your mastery of controlling emotional responses.

Discussion

Care is Not for Sale

One of the final questions participants were asked was, “What do you think it means to be paid to care?” Inevitably, this question was something the RNs found problematic. One of the ultimate aims of this project was to examine nursing as care work, as part of a larger economic system that has increasingly outsourced women’s traditional domestic unpaid labor to outside of the home, including the paid caregiving, from health to child care . However, the nurses interviewed did not see their work in economic terms. Here, this nurse sees her occupation as a master status, as an integral part of her identity.

I don't even think about that. Nursing is just what I do. It carries through everything, whether I am in work or outside of work. And other people, they look to me for that direction. I don't think of it as "paid to care" It's just what I do. I think it is part of what you do as a nurse. I suppose you could go through the motions, you could do the physical work of the nurse without caring. But knowing people the way that I do, they'll be able to feel it. You'll be able to feel it. It's not going to be, it's not just the physical job. It's that emotional connection you make with people. It's just what you do. So as a nurse, that's just what I do. Could I do my job fully if that piece was missing? No, I couldn't. If I had done something else, like sales, I would be bored. I could still connect with people, but I would feel like I was missing something. You have that kind of personality in me.

But there is a difference in caring, nurturing, dealing with the whole person, that is different when I am working as a nurse. And I don't think you could be a really good nurse if that was missing.

Here, Allison responds, equally perplexed at what nursing would be without a caring component.

I do not think I am paid to care. I am paid to manage Pitocin, start IVs, physiologically deliver babies. I am not paid to care. I care because I care. I do not think it is possible to force someone to care. I get paid to manage a checklist and the other stuff is extra. I don't think I could do this job without caring. Some nurses can do this job without caring. For me, the caring is what makes it worthwhile. If I stopped caring about every kind of patient- there is always a spectrum of how much you care- if I stopped caring in general, I wouldn't do it. It's a lot of work and risk. It's the highest sued specialty. If you didn't care and love it, then why do it? It's the main part of doing it. I don't understand why you would do this if you didn't care.

While she admits there are some nurses who do not genuinely care for patients, she does not understand their motivation. Bolton's conceptualization of "caring as a gift" in nursing seems in line with the Allison's view. The clinical work as a nurse is the portion that has economic value, but the caring is extra.

This distinction between clinical work and care work is further explored in Lynda's answer.

I understand how a hospital works and I have to play within the rules for a paycheck. That's my choice. And so, what does caring mean? Everyone's definition of feeling care is different. I mean, if your definition is the patient is safe, like that is the baseline, then a

nurse should lose their license if the patient is unsafe. Otherwise, you can't get paid. Our setting is not set up for labor support. I don't know that it is the role of the nurse in our environment, the system we have set up.

So, I think there are nurses I know that do it because it is a reliable job and you get paid. But there is a different level of caring. What caring means is very different to people. The nursing skills, everyone is taught as a baseline. Everyone that is a nurse can reasonably do them. But then there is the caring, what motivates you to be in that particular job or field, and that is what you add to it. So, I guess to say, that that care that they are paid for is not going to be the same, depending on who your nurse is. Despite them all being trained with the same skills. Waitressing prepared me for this more than anything, like how to do ten things at once.

Her words place care on a spectrum, along with clinical skills, with basic safety as a bare minimum. The comparison to waitressing is striking, as it implies a service, task-based occupation with little prestige or professionalization. In a different interview, someone else also compared nursing to working as a waitress, with a splitting of attention and constant fetching of supplies.

Lynda, a former OB nurse turned midwife explained, “ I see plenty of nurses who don't care. Maybe they did once and are too burned out to care anymore. Maybe they are just going through the motions. But you aren't doing it right if you don't care.” Raquel did not even conceive of not genuinely caring for her patients on an emotional level, as she explains in this passage:

I do not want to sound like a goody-goody, but I always care. Even if I am lazy sometimes, I always care. I can't not care. It is my responsibility. But getting paid for it, I

mean it is still a job, a profession, I think you should get paid. But for caring, it is just a natural thing. We are getting paid for taking care of someone, not for actually caring.

There are some people you get a connection and you hope it goes well. Sometimes, you are like, I just can't think it about it anymore. But I cannot not care. I have to. There are times that I don't know you personally or emotionally, but I care that you are alive.

Effervescence: The Magic of Birth

Overall, the participants derived meaning from their work and described emotional aspects as fulfilling. The moment of birth was depicted as a quasi-religious, mystical moment within the aspiration of a “nice delivery.” Most nurses seemed to genuinely love being a part of birth, although there was often a sense of fear or anxiety around labor. The excitement of birth and witnessing the moment was expressed with awe. This nurse Candace so eloquently shared her way of looking at birth and what it means for her work:

I love deliveries. I love being in the room for it. Each delivery is exciting and still makes me nervous and still makes me happy. I think it is the coolest moment to be there for someone's first moment in life. To be there for someone's very first moment on Earth. I think of it as another state when they are inside. I love this moment, not every time, when the head delivers, and they already look around, like “What is this?” It is my favorite moment. It is like they are half in one world and half in another. You are witnessing the first moment that they are seeing this new world. Seeing this moment when a mother and a father see their kid, like this person has been growing inside of you for almost a year and you love it more than anything- it's just innate. You are going to love it for the rest of your life. Until you die, this baby is going to be the most important person in your life.

And we have the privilege to be there. I think it is just the coolest. And I really don't want to be without that.

The nurse sees her work as a privilege. So many occupations lack this sense of wonder and purpose. Often, OB nurses had difficulty explaining the raw emotions of joy, but some tried, like Tonya in the following passage:

The first emotion that comes to mind, I know, this is so cheesy and repetitive, but when you have a planned, happy birth and both the patients are excited and supportive and the mom and dad are both crying. That, to me, is the most overwhelming emotion and sense of satisfaction to just finally see this family come together. So that is the immediate emotion. That's it. I know that's the movie-theater-emotion that everybody sees, but it really is magical.

Nurse Irma shared a similar sentiment, "This is going to sound cheesy, but I really like the miracle of life. (laughs). The deliveries. When the baby is born, you know?" Annette described her joy as,

I think I have, even on those super-joyous moments, like I-am-going-cry moments, when you have a really awesome birth experience, you see where a baby become part of a family. It is going make me cry now! It's like a family. You see all this anticipation come up and then happen. That's really awesome.

Former OB nurse Maryanne looked back fondly at the "effervescence" of birth in analogous way.

You weren't just dealing with the mommies, there was the dads, the siblings, the grandparents- they would be so excited, and you'd get so excited for them. Like, oh, wait,

this isn't my baby! But it was such a wonderful thing to see, so great to stand in the background and see it happen. Like every day I got to see this great thing happen. It happened every day. Like yeah, I gotta go to work, and it will be hard, but in the end, I get to be part of it. It is a bubbly feeling, an effervescence.

Overall, the participants derived meaning from their work and described emotional aspects as fulfilling. A nurse with over 40 years of bedside OB experience told me, with tears in her eyes, "It is still is a miracle every time I see a baby born." A newer nurse, less than two years in her practice had a similar reaction, "I enjoy getting to know the mom and being their support for the whole process. I remember seeing my first birth during clinicals, and I was like 'Yeah, this is definitely what I want to do.' Kind of scary and cool at the same time." This refrain of effervescence, the joy of birth, was a driving force in the words of OB RNs.

Nursing, Birth and Technology

Despite the positive experience of working with the joy related to birth, there are also problematic issues. There exists a tension in nursing practice, just as there does in much of society, between the promise of the convenience of technology and the resulting impact once it's been introduced. New technologies come with unintended and unexpected consequences. In some ways, technological advances have made some things simpler, yet some are much more complicated. We have access to a great deal of information, yet don't always have the ability to understand it. There is often a layer of technology between our interpersonal interactions. Natural birth advocates have said that the introduction of technology into birth is misguided at best; at worst, it is nefariously undermining women's bodies to strategically undermine their power. However, this intersection of birth and technology is experienced by obstetrical nurses, the very people working in this arena, differently.

Karl Marx and his theoretical adherents have long decried modern work in a capitalist system as alienating. When OB nurses describe their relationship with charting, the Marxist concept of alienation is fitting. Charting is best defined as the (often electronic) documentation of patient care, and in OB, includes the ongoing assessment of the “strip,” the combination of continuous fetal heart monitoring, uterine activity and vital signs. Charting evolved from updating the paper record as a communication tool amongst the health care team, tracking trends and treatments, to a far more detailed legal record of surveillance.

OB RNs largely reported that they hate charting, but rarely do they admit to not completing it. A veteran nurse claimed, “We used to just follow the screams to know who was ready to deliver, but now we just take care of a computer.” Not completing the required charting is not even mentioned as a possibility, as OB nurses seem to have internalized the imperative refrain of “If it wasn’t charted, it wasn’t done.” Several of the nurses described staying after their twelve-hour shift, often unpaid, to complete their charting. Nurses saw charting as an immutable duty of their job, a necessary, unescapable misery that took them away from patients, chained them to a computer yet protected them from the specter of a future lawsuit. In OB, lawsuits around birth trauma can be years later and the nurse called to deposition may not recall that patient or case, with only their charting to support their assertions that there was no negligence, wrong-doing or inappropriate actions. This self-imposed, charting imperative guilts nurses to act as their own enforcers of a practice that is largely a waste of time and unproductive. In Jeremy Bentham’s metaphor of the panopticon prison applies here, which eventually creates self-policing behavior as a consequence of constant surveillance OB nurses do not know what patients may end up in a court case in the years to come, and therefore they see charting as protecting themselves, doctors and the hospital, in the prospect of a malpractice lawsuit.

Take the words of Agnes, “Charting is my number one dislike about my job. Along with that, the constant threat of , ‘If this ever goes to court...’ You are living under that idea. Everything you are doing is to cover your ass. Charting is really a ‘cover your ass’ scenario and not geared towards communication.” Allison described charting as “a detriment. Pages and pages of charting. I don’t like to chart in the room because I feel like I am not looking at the patient. It hurts trust. It feels like a TV in a restaurant. I hate that.” This description of “feels like TV in a restaurant” is another in vivo code for alienation in nursing work in relation to technology. Robbie Davis-Floyd’s idea of the technocratic model are in alignment with this theme. A restaurant is considered a place for connection and conversation over a meal, not digital distraction. By placing charting in the center of the nurse/patient relationship, a technological barrier disrupts this connection.

For example, an OB RN can be assigned an admission of a patient in labor. In addition to the technical tasks of starting an IV, drawing labs and gathering pertinent supplies, the nurse may also be simultaneously asking the extensive admission questions, all while monitoring the continuous strip. This must all be documented in the chart, whether in real-time as purported best practice or back-charted, as is often the case. The act of typing into a computer intermittently while performing tasks, monitoring the strip and also interacting with the patient, ideally in a compassionate manner, can be distracting and a barrier to remaining focused. This is more than just multitasking, requiring more than merely prioritizing skills. The internalization of the absolute importance of constant and consistent charting by the nurse leads to alienation by the doctrine of obligatory documentation. By adhering to the adage, “if it wasn’t charted, it wasn’t done.” the very occurrence of reality is called into question. Nurses spend hours typing into an electronic medical record, essentially recreating their actions and documenting their observations

as they happen, depicting a clinical picture with disembodied language and repetitive notations, to prove their work happened. Communication of the patient condition and monitoring for trends is the explicit rationale for documentation, but OB nurses will tell a more complex story, that includes mind-numbing data entry of “strip charting,” despite the fact that the strip is already stored electronically.

As obstetrics moves towards Davis-Floyd’s technocratic model, the body-as-machine metaphor is taken a step further, where the monitors are measuring the labor, not the nurse or patient. Here, a midwifery student and OB RN laments the impact of technology:

All across OB, we see it. It’s everything. It’s how we do our assessments. It’s like monitoring. Like we monitor a patient. When it is a mom in labor, It’s all high technology. I think we lost a lot of skills that were previously nursing skills. Like just sitting there waiting and feeling contractions. It’s something that you don’t do. It’s how you get trained. It is something that you don’t do. You watch the monitor. And it’s just how it is. As technology comes in, certain softer skills get lost.

Some veteran nurses do question the necessity of the burden of obligatory documentation, perhaps because they recall a time prior to its centrality. Jody, an OB RN with nearly twenty years in the field, shares her impression on changes:

When I started, I felt like we had so much more time with the patient. Paper charting was totally different. a quarter of what we are doing. We would chart directly on the strip, which is kind of helpful. There was still central monitoring. But there wasn’t all this extraneous, crazy stuff. It seems like now things are redundant. Like the doctors are charting a lot of the same stuff. There are a lot of details we could leave out, especially

for the area of care that we work in. The other thing is the liability. Back when I started, we were doing vaginal breeches, way more VBACs. I mean some of the stuff that we chart, what kinds of distraction devices they are using in the room? That is a detail.

She specifically calls out the relationship between liability and redundancy in documentation, finding fault with the way legally defensive charting impacts nursing practice. Another seasoned nurse said plainly, “I feel like it is taking care of the computer instead of the patient.”

Nursing in Constrained Contexts

Beyond the alienation of charting and the technological influence, other issues combine to negatively affect nurses. Sources of frustration included a lack of respect, a profit-driven system, and an inability to provide the safest care within those restraints. This nurse encapsulates one of the key issues of OB nursing, how to keep a humanistic stance in a cold bureaucracy.

I mean, there are still times, like when a dad cries when a baby is born, I still cry. There are certain interactions between a couple when a baby comes into this world that will always move me. On the other side, I get very frustrated with the work environment, and people not doing what is best for patients. I mean that's why we are all here, right? We took an oath or made a promise to do the best we can and provide the best care. People forget that sometimes. I know I do sometimes, and I have to remind myself. Frustration is big, especially with higher-ups and business people dictating what is happening in health care.

This issue of budget-driven care arose, along with the general lack of respect for nurses from management. Nurse Irma comments, “I hate the politics of it. It is a lot about budget, keeping the doctors happy. That gets in the way of the patient, of taking care of the patient in the safest way.

The appropriate way. That's what bothers me.” The safety imperative, an organizing principle of the OB nurse, is endangered by financial restraints and medical dominance.

In earlier passages, Tonya lamented the waste of resources in her hospital and this was not unique. These nurses are seeing larger systemic problems play out in their work environment, with little sense of recourse. Lillian takes a paternalistic tone about the “girls” who don’t follow the rules, showing up at a different hospital to deliver, focusing on the noncompliant patient wasting resources, instead of looking at the structural issues of lack of coordination in a fragmented system.

When we have ER walk-ins, it is so frustrating. They roll in here, knowing they are supposed to deliver somewhere else, with these unrealistic expectations and they don’t follow the hospital rules. It is so frustrating because we have to re-draw their labs, treat them for unknown GBBS+. I wish there was a way to explain to these girls, this is not how it works. They have no idea, that someone else has everything we need, and we can’t access it. Like their medical records.

It is redundant to provide this care, but lack of patient education on the health care delivery process is a small piece of the puzzle. Lillian explains the further strain of walk-in patients in labor, “Then they stroll in for the delivery- especially at night, when we are short-staffed. Our manager is insanely cost-driven. They should never hire a manager who has not worked as an OB nurse, they just don’t get it.” The lack of support for nurses and dissatisfaction with management place further stress on the unpredictable workloads in OB nursing.

Here, Candace names bureaucracy as the ultimate culprit of dissatisfaction and frustration in her work.

There are so many little annoyances and you feel like you can't keep up. The most frustrating to me is when there are things that don't work. All those little things add up and prevent the day from going smoothly. Like the computer is down, the tube system isn't working, and my patient's blood is sitting there, or the blood pressure cuff won't work. And when other people don't think of the big picture, like when coworkers are inconsiderate. And, the bureaucracy.

Those little annoyances, in part, are directly related to bureaucracy and lack of nursing input and depleted resources. Luz mused that if nurses made decisions, even the patients' rooms would be designed differently, more intuitively for the work of a nurse. Despite the constraints described, some nurses still find meaning in their work, like Agnes in the following passage: "I still love my patients. I still enjoy getting to know my patients. I still love babies, after all this time. Kinda ridiculous, after all this time. It is actually the direct work. If I didn't have to chart, if I didn't have management, I would have the best job in the world, in the whole world."

Despite the effervescence of birth as a theme, a nurse explained how birth can become routine and how her discomfort led her to become a midwife.

Sometimes there's births that are just like, its rote. It's weird to say. It's awesome to see a family happen. There can be really, well, I've gotten better at dealing with it, but it can be frustrating when they are getting this one package fits all treatment and they are not given other options. And that is why I became a midwife. Because I cannot not have to deal with that. I can change that.

She found a path for agency to make birth less institutionalized, but this is not the norm. For most nurses interviewed, medicalized hospital birth was their routine, shaped by risk and safety,

yet they found meaning in birth and care work despite bureaucratic and technological restraints, within a larger social cultural context.

Conclusions

Perspective matters. If these nurses were being exploited, selling their biology-programmed loving tendencies unwittingly, why do they report feeling the caring and human connections are the best part of their occupation? Unexpectedly, nurses found a way to have their “natural” care and compassion validated, to have work that feels meaningful. Are they exploiting the system? This is the question of agency and also relativism.

Here is a major finding of the research: The participants described their work in terms of relationships and connections. Their viewpoint was based from an ethic of care, like Carol Gilligan’s point that women are more likely to value relationships. As these nurses declared care work is meaningful, they are choosing to reject an exclusively capitalistic model. Politics around birth practices, with the contrast of the home birth and technocratic, medicalized model misses the point of experiences of these women who work in obstetrical nursing. By valuing genuine care, the relational stance of these nurses can be political in its own way, a way of calling for occupations to provide fulfillment.

There is something to the unintended consequence of the human, social and emotional aspects of a health care system, that “the human touch,” the nurse’s care, is something that cannot easily be quantified, replicated or commercialized. The reason nurses bristle at scripting, at AIDET, and patient satisfaction metrics is they KNOW how to care for patients. The problem of patient satisfaction metrics for nurses is not that they do not know how to provide excellent care, but rather they are constrained by the ever-present burden of productivity, the dilemma of

too much work within time constraints. A nurse's completeness of charting can be objectively evaluated, or the number of appropriately timed medications given can be measured, but it is harder by far, maybe impossible, to track how well a nurse "connects" to her patient. Anyone who has ever been sick or hospitalized knows the difference when a nurse is "good." Clinically competent may not be enough to make a patient feel cared for. There are plenty of trite platitudes and saccharine tropes about nursing, but perhaps they survive because there is a phenomenon that occurs in the nurse-patient relationship that is significant.

Nurses' voices matter. Nurses find their work meaningful and the caring aspect is more fulfilling than the bureaucracy. Nurses blend clinical and emotional, and make it look easy, but it is not. OB nurses have a distinct opportunity to bond with patients as they experience childbirth.

This project has been largely descriptive in nature. The expected result was to find burned-out, exploited nurses pretending to care. Instead, the research showed professional nurses who found deep meaning in their work, convinced their caring was genuine. The main sources of frustration were lack of respect, bureaucracy, a profit-driven system, and an inability to provide the safest care within those restraints. The major implication would be to promote understanding of the substantial work of nursing, to encourage agency for nurses and to continue to build a sociology of nursing. Valuing the perspective of nurses is the first step to valuing their work, a shift that must occur if nurses are to impact policy.

A second major finding was how the nurses did not mention their part in the bureaucratic, reproductive mechanism, with the hospital as an infant's first experience within an institution. As hypothesized by Davis-Floyd, the technocratic nature of modern birth was not seen in problematic terms, for most participants. Nurses often unquestioningly completed their charting duties and internalized the safety imperative. They proudly described themselves as the "eyes" of

the doctors on patients, engaging in constant surveillance of fetuses, with a significant portion of their work and expertise centered around continuous electronic fetal monitoring, in a Foucauldian manner. They expressed frustration at a health care system filled with fraud and abuse by patients. Some noticed how their race, class, gender and social factors played a role in their jobs, but many insisted on their “color-blind” approach to patient care.

The participants interviewed did not remark how they surveil and process humans into a bureaucratic system. The performance of the bureaucratic activities of reproduction like filling out birth certificates, admitting and banding babies with alarms, creating a chart and an MRN, completing birthing records and filing statistics, measuring and foot printing, and consistently documenting vital signs, was entirely unremarkable to the participants. The fact that our society requires an identification number and computer-generated band at the moment of birth is telling, especially in the technocratic model of Floyd-Davis. These types of activities are in fact reproducing society and demonstrating our values within the arena of biological reproduction. The centrality of charting is further indicative of the bureaucratic technocratic nature of social reality, that “if it was not charted, it was not done.” If a baby is born at home, is it born? The medicalization of birth further serves to reproduce social institutions and technocratic bureaucracy.

That nurses profess to enjoy to the magic of birth and the relational meaning of caring in their work does show both a blindness to their role as enforcers and processors of dehumanized medicalized reproduction, but it also demonstrates a desire to focus on the more emotional and fulfilling parts of their work. The meaning of paid care work was subverted by these nurses as meaningful, rather than exploitative or problematic. Similar to Davina Allen’s appeal to build a sociology of nursing, there should be more occupational studies of nurses work beyond obstetrics

to compare these results across specialties. As nurses' work and their voices are examined, their perspectives on the nature of work and healthcare institutions become visible. With that visibility, can come voice, agency and possibly change on a system level.

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