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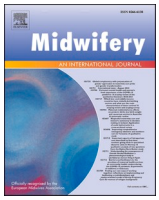

Research Article

Navigating a maze: Midwives' identity response to the enactment of an abortion law in Chile

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ABSTRACT

Background: Chilean midwives have been identified as essential for successfully implementing an abortion law, a practice which could potentially be understood as contradicting their central mission. Nevertheless, to date, there has been no investigation into how Chilean midwives have incorporated induced abortion care provision into their professional identity.
Objective: To elucidate how Chilean midwives understand and provide abortion care and how they have (re) defined their professional identity to include induced abortion care. This article reports the findings of the second part of this aim.
Methods: This study was underpinned by a constructivist grounded theory methodology informed by a reproductive justice and feminist perspective. Midwives from Chile who have cared for women undergoing abortion were invited to participate in the study. After purposive and theoretical sampling, fifteen midwives were recruited.
Findings: Midwives' identity is woman-centred, with high value placed on their role protecting life. These two aspects of midwives' identity are in contradiction when providing abortion care. Midwives' identity results from and informs midwives' practice. Midwifery regulation influences both practice and identity. The model 'Navigating a maze' explains the interaction of these three elements.
Conclusion: Midwives' identity response to the enactment of the Chilean abortion law is an example of how professional identity must navigate regulation and practice to make sense of its purpose. In light of this study's findings, the current tension experienced in midwives' identity should be carefully attended to prevent adverse outcomes for midwives and the Chilean population.

Background

In 2017, Chile decriminalised abortion in three circumstances, when a woman's life is at risk, the fetus will not survive birth, or the pregnancy resulted from rape (Ministerio de Salud, 2017). Under any other circumstance, abortion is still punishable with incarceration for the woman and any other person assisting (Ministerio de Justicia, 1874). Gestational age limits on abortion do not apply in the first two clauses (Ministerio de Salud, 2017). Nonetheless, for rape-related pregnancies, abortion must be conducted before the 12th gestational week for women over fourteen years old and before the 14th week of pregnancy for those under this age (Ministerio de Salud, 2017). When a woman's life is at risk, one physician must authorise the abortion (Ministerio de Salud, 2017). Two medical specialists must corroborate the lethal fetal condition (Ministerio de Salud, 2017). Before obtaining abortion, rape survivors require that a medical team corroborates their story of the assault (Ministerio de Salud, 2017). Before the current law, *therapeutic* abortion was lawful in Chile between 1931 and 1989 (Ministerio de Bienestar

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Social, 1931; Ministerio de Justicia, 1989). However, after a right-wing coup in 1973, the former constitution was replaced by the current one, which stated that the law protects the unborn's right to live (Chile, 1980). Consequently, during the last year of dictatorship, *therapeutic* abortion was overturned (Ministerio de Justicia, 1989).

Midwifery training in Chile has always had the life and health of the fetus in high regard (Rodríguez-Barro, 1918). However, historians show that the medical community blamed the increasing rate of illegal abortions and its consequences on midwives during the first half of the 20th century (del Campo-Peirano, 2008; Zárate-Campos and González-Moya, 2018). By the 1950s, midwives abortionists were seen as damaging midwifery's prestige (Zárate-Campos and González-Moya, 2018). Currently, midwives are integral to the provision of abortion care while being forbidden to conduct the procedure itself (Ministerio de Salud, 2018b). Primary care midwives will identify and refer pregnant women with high-risk conditions to secondary care (Ministerio de Salud, 2018b). In secondary care, midwives and obstetricians will care for women undergoing high-risk pregnancies, including those with a fetal lethal condition or who could develop a condition that threatens a woman's life (Ministerio de Salud, 2018b). Women after rape and undergoing a life-threatening situation are likely to access the system at tertiary or primary care (Ministerio de Salud, 2018b). Midwives at tertiary care will be working in the obstetrics and gynaecology emergency triages, providing midwifery care at the tertiary high-risk pregnancy units where abortion inductions and post-abortion recovery will take place, and managing maternity theatres where surgical abortion will be conducted (Ministerio de Salud, 2018b). Medical abortion is also available for women undergoing abortion, and it includes the use of mifepristone and misoprostol (Ministerio de Salud, 2018b).

The discussion of the abortion bill was polarised. The bill was far from what feminists wanted to secure for Chilean women (Piquer, 2019). Nonetheless, however insufficient, the abortion bill was better than nothing (Piquer, 2019). More about how civil society organised in the face of the introduced bill can be found in the book 'Aborto en tres causales en Chile' (Casas and Maira, 2019). After the parliament approved the abortion bill, conservative parliamentarians filed two motions to declare it unconstitutional (Biblioteca del Congreso Nacional de Chile, 2021). The Constitutional Court accepted one of the motions and extended conscientious objection to institutions (Biblioteca del Congreso Nacional de Chile, 2021). Chilean individual conscientious objection to abortion is contextual and restricted to the care provided in the maternity/surgical theatre (Ministerio de Salud, 2017, 2018a). Therefore, a midwife who objects to providing abortion care to a woman in the theatre could not refuse to prepare her for abortion or provide her with post-abortion care.

The philosophy of midwifery care 'promotes, protects and supports women's human, reproductive and sexual health and rights, and respects ethnic and cultural diversity' (International Confederation of Midwives, 2014a, p.2). Midwifery care encompasses competent and safe provision of abortion-related services that ensure women's well-being (International Confederation of Midwives, 2014b). In line with this, the World Health Organization (WHO) agrees that midwives can be abortion providers and conduct surgical and medically managed abortions under 14 weeks of pregnancy, including the use of vacuum aspiration (World Health Organization, 2022).

For some midwives, however, abortion is perceived to be the opposite of their traditional role, causing conflicts with their professional identity while working in this area (Cignacco, 2002). When midwives exercise their professional role, they are also enacting their professional and personal identities (Cruess et al., 2014, 2019; Ellemers, 2017; Scheuringer, 2016). Professional identity sets the values an individual must abide by to be acknowledged as professional while providing a framework for practising and a locus from where to create meanings and connections (Albert et al., 2000; Cruess et al., 2014; Hogg and Terry, 2000). However, while setting boundaries, professional identity can also challenge intra- and inter-professional interaction, paradoxically reducing a professional's scope of practice and testing interprofessional practice (Kreindler et al., 2012; Larsson et al., 2009; Lundborg et al., 2019; McNeil et al., 2013).

The aim of the study was to elucidate how Chilean midwives have (re)defined their professional identity to include abortion care after the enactment of the abortion law.

Methods

This article is part of a larger study that explored how Chilean midwives understand and provide abortion care. Regarding this, midwives' experiences showed that abortion care was challenging in part because of the emotional labour it entails. Furthermore, abortion puts into tension the woman-centred ethos of midwives and their relationship with the fetus. These results, in more detail, are published elsewhere.

Theoretical approach

The study was underpinned by a constructivist grounded theory methodology (Charmaz, 2017a). Constructivist grounded theory methodology is rooted in a relativist ontological position and a subjectivist epistemology which acknowledges reality as a co-construction between participants and researchers (Charmaz, 2008; Mills et al., 2006). The study was also informed by reproductive justice and feminist perspectives. Reproductive justice and feminist perspective are consistent with constructivist grounded theory methodology's understanding that phenomena are shaped by social context, history and the intersection of multiple dimensions of individuals (Charmaz, 2017a; Mills et al., 2006; Ross, 2017). Constructivist grounded theory was considered the best approach to use in this study as it could enable the development of a model that explained midwives' identity response while acknowledging the model is context, participant and researcher dependent (Charmaz and Thornberg, 2021; Urquhart, 2013). Furthermore, a model could help inform policy design and implementation processes, making the research findings more helpful for promoting change (Charmaz, 2017a).

Participants

Midwives working in Chile were invited to be part of the study based on their exposure to the phenomenon of interest. The first five midwives interviewed in the study were purposively sampled using maximum variation criteria considering their gender, working experience, conscientious objection status, area of work and geographic location of their work. Three midwives' gatekeepers (one man and two women) working in different settings and from different geographical regions were asked to identify possible participants and spread the information about the study. Participants interested in participating in the study contacted the first author directly. After this, the first author sent the participants the study's information sheet and the informed consent form. A follow-up email or text was sent to the participants no less than 48 h after sending the documents to see if midwives had questions about the study. Gatekeepers were unaware of those who agreed to take part in the study. Further participants were identified through snowballing during theoretical sampling. In keeping with constructivist grounded theory methodology, the recruitment of participants progressed according to constant comparison analysis findings until reaching theoretical saturation. The team agreed on theoretical sufficiency after fifteen interviews once it became apparent that no new information about the phenomenon of interest was being heard in the interviews.

Data collection

The study was conducted using online interviews on Zoom. Online interviews were considered appropriate to interview midwives regardless of where in Chile they were based and to prevent the spreading of Covid during the data collection. Interviews were conducted between

February and October 2022 by the first author. The interviews were scheduled according to each participant's convenience. Participants were asked why midwifery was chosen as a career and their experience caring for women undergoing lawful abortion. Probing questions such as 'Could you tell me more about that?' and 'Could you explain that a bit further?' were used to encourage participants to provide more in-depth information about the phenomenon. In line with theoretical sampling, extra questions were added to the interview guide to further explore tentative codes and categories. Questions such as 'How did you decide your conscientious objector status?' and 'What is your opinion on the abortion law?' were included during theoretical sampling according to each participant's profile. Interviews were conducted in Spanish, which is the official language of Chile. All interviews were audio recorded, transcribed verbatim to Spanish and then translated into English by the first author with participants' consent. Translating the interviews to English before coding was necessary so that all team members could be actively involved in the analysis process. Translation accuracy was assessed by a midwife who is also an academic at a university in Chile. Due to the extensive use of midwifery slang during the interviews, it was deemed necessary that whoever approved the translated interviews had to be knowledgeable in English and midwifery. Translated interviews were uploaded to NVivo 12 Plus for data management.

Data analysis

Data analysis in the study was conducted using a constant comparison method. In this method, data collection and analysis occur simultaneously so that codes, concepts and categories are compared to each other and against new data, allowing the studied phenomenon to be redefined (Charmaz, 2017b; Glaser, 1965). After translation, interviews were read by all team members and openly discussed to gain further insight into the participant's narrative. Each interview was coded incident-by-incident by the first author. Similar codes were grouped into sub-categories that later informed major categories that allowed understanding of Chilean midwives' perception of their professional identity and experiences when providing abortion care. Memos of possible categories and rationale for decision-making were also used to inform the categories of the study. Categories were agreed and developed after consensus by the research team.

Reflexivity

Constructivist grounded theory assumes reality as a co-construction and upholds the impossibility of producing *objective* knowledge (Charmaz, 2006). Within this philosophical stance and for feminists, it becomes essential to be transparent about the researchers' influence on the research product (Hesse-Bibber and Piatelli, 2012; Olmos-Vega et al., 2023). Regarding this, the first author is both a feminist and an advocate of reproductive justice, stances which are supported by the research team. The feminist perspective used in this study was most important considering the study was focused on midwives, who are most often women who care for other women, and abortion care. However, it was important that the first author's philosophical stance on these matters was not disclosed to the participants. This was particularly felt to be important in case any of the participants felt their involvement with abortion would be perceived as wrong.

The research team comprised four midwives, one Chilean registered (BC) and three UK registered (HW, AT and AC), and one UK registered nurse (JB). JB also has academic expertise in religious studies and healthcare ethics, which supported a nuanced understanding of participants' beliefs in the generated data. The first author conducted the interviews; hence, she disclosed, when relevant, her background as a midwife. However, the first author also made clear that she had no experience providing lawful abortion care. As such, the first author was a partial insider to the studied phenomenon (Dwyer and Buckle, 2009). After concluding the interviews, several participants commented on how much they felt heard and how cathartic the interview was to tell their own stories. Not sharing the experience of providing lawful abortion care may have encouraged participants to communicate and provide further detail on their experiences, as they could not assume that the first author understood this particular aspect of their practice.

The first author led the design and analysis of this study. Regarding her position on abortion, the first author believes that deciding to continue a pregnancy or not is a woman's choice. However, as the member of the research team that interacted with participants, the first author was aware of how important it was to be open to other people's opinions on this matter. During the study, the first author reflected in private, using a reflexivity journal about her feelings and assumptions, especially before and after conducting the interviews. The first author received debriefings during periodic research meetings. The research team held periodic meetings to discuss findings and recruitment strategies after reflecting on the team's presuppositions about the phenomenon and participants. The diversity in researchers' backgrounds allowed a balance perspective about the studied phenomenon.

Ethical considerations

The study was granted ethical approval from The University of Manchester Research Ethics Committee (Ref: 2021–11778–20713) and the Research Ethics Committee for Human Studies from The University of Chile (Ref: 172–2021). All participants were provided with an information sheet and a copy of the informed consent form in Spanish. Participants could ask questions about the study in Spanish or English before deciding to join the study. Before the interview, participants provided their written and verbal consent to be interviewed. To ensure participants' anonymity, pseudonyms are used at the end of quotes and participants' data has been described to prevent secondary disclosure.

Results

Fifteen Chilean midwives participated in the study. Nine participants had provided abortion care. All but two interviewees were women, five were atheists, two participants declared to be conscientious objectors to abortion, and one participant declared to belong to an ethnic group. The working experience of the group ranged from 4 to 42 years, with a participants' median age of 33 years. The interview durations ranged between half an hour and an hour and forty minutes.

Midwives' identity model

The core category for this study has been named 'navigating a maze'. This core category encompasses three major categories: midwives' identity, practice, and midwifery regulation (Fig. 1). 'Navigating a maze' explains midwives' identity response to the enactment of the new abortion law in Chile. Like in a maze, midwives' identity navigates the changes induced by regulation and practice. As in a multicursal maze, midwives' identity navigates with a set direction and across multiple paths, which can lead to their desired destination. In this model (Fig. 1), regulation related to a midwives' maze. Technical protocols and guidelines will direct the path midwives' practice must follow and provide advice on how to manage challenging situations while walking the paths. Midwives' identity can be understood as the mindset informing navigation decisions. When informed by a woman-centred mindset, abortion is a woman's opportunity. When informed by a guardian-of-life mindset, abortion is understood as a loss of life. Mindset is not static through time and will be forged and tested by day-to-day practice. Likewise, practice will embody the midwives' mindset, as their experiences shape them as professionals and inform their future actions. This is how practice will inform identity, and identity will allow midwives to (re-)interpret practical experiences. The model for 'navigating a maze' (Fig. 1) is grounded on this study's data and inspired by literature from critical management studies (Alvesson and Willmott,

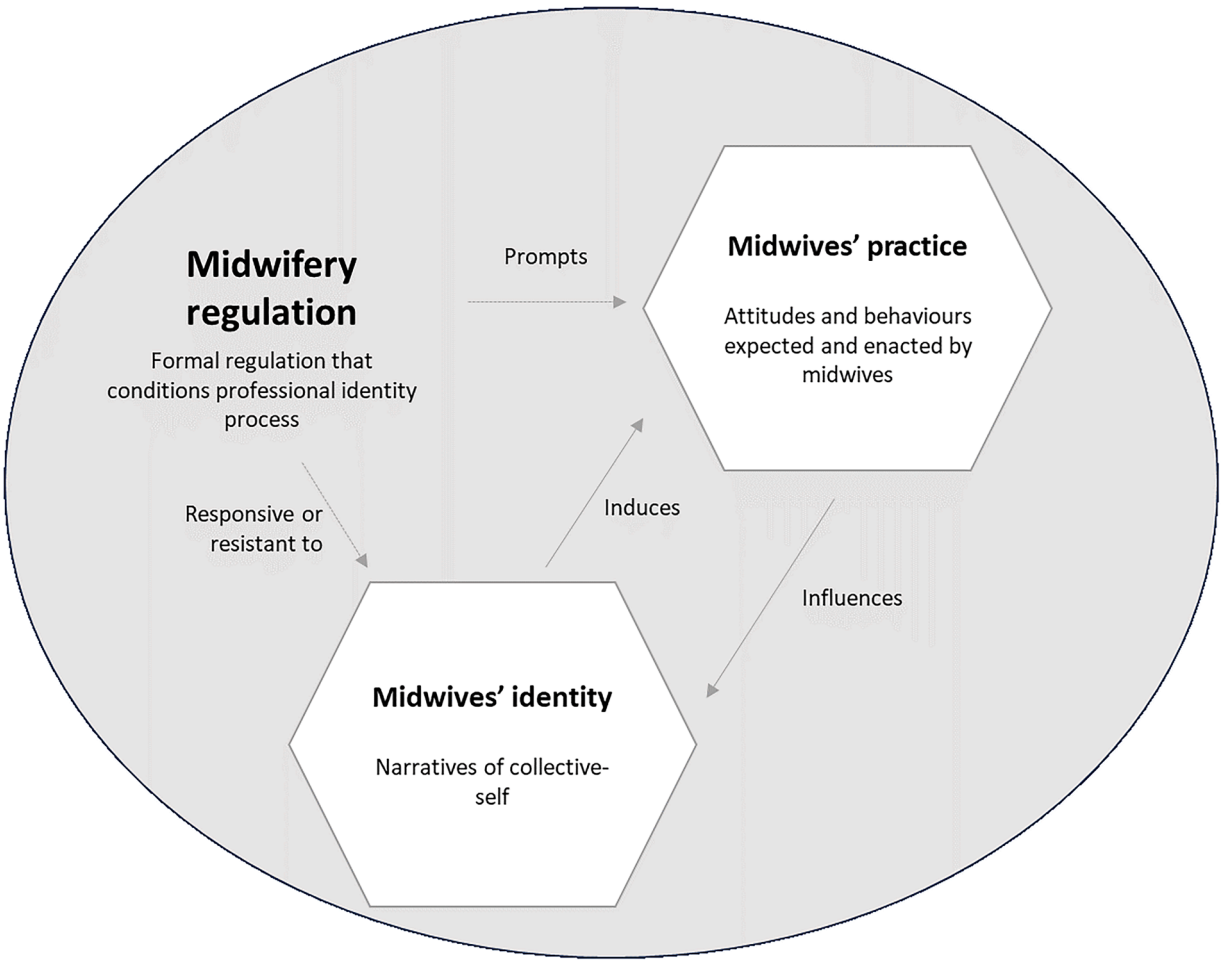

Fig. 1. Professional identity regulation model. 'Navigating a maze'.

2002).

In the model, midwives' identity results from and informs practice in an iterative process. Thus, the model indicates that these two elements are interdependent and dynamic through time (Fig. 1). When a change occurs in identity or practice, it cascades in the remaining element, altering both. For instance, providing abortion care influences midwives to ask themselves about their identity within abortion. Positioning themselves regarding abortion, even if transitory, will lead midwives to practice from a different perspective. This new perspective may not necessarily translate into a change of practice. Nonetheless, the personal interpretation given to the practice could result fundamentally different.

Changes in midwives' practice could result from introducing or removing technological procedures in clinical practice, updating guidelines and laws regulating the profession or procedures, and revising the codes of conduct for midwives and other professionals in direct relationship with the provision of midwifery care. In what follows, the model is used to describe midwives' identity response to implementing an abortion law in Chile.

Major categories

Midwives' identity

Midwives' identity refers to the self-narrative midwives have about themselves. To understand this, an overview of why midwives decided to become midwives and what midwives' identity means for them will be provided. Midwives' self-narrative includes how they see themselves from an internal (being midwives) and external (wanting to be midwives) point of view.

Wanting to be a midwife

During all the interviews, midwives described a strong sense of belonging to their profession and recognising themselves as midwives. Several midwives stated vocation as their reason for choosing midwifery. Even midwives who were unclear on their reasons for entering the degree described romanticised feelings:

'I slowly fell in love with midwifery' (Diana)

When asked where the inspiration to become a midwife came from, most reported positive encounters with a midwife.

Interviewees' perception before entering the degree mainly describes midwives upholding positive values as being knowledgeable, autonomous, reliable, and woman-centred professionals, valued by the community where they provide continuity of care. These positive characteristics of midwives are reinforced during university and embedded in midwives-to-be as core qualities of midwives' identity in a cyclical process. Elsa reports that she:

'… [D]id not know how vital midwives are to a woman's and people's lives. [I] only managed to understand [midwives' impact] during [my] senior year, [learning] which was later reinforced once [I] practised'.

As Elsa suggests, midwives' identity construction during training is enriched and solidified by clinical practice when interacting with other midwives, clients, and the broader healthcare team. Midwives' professional behaviour is also an essential element in deciding to become a midwife:

'When I started studying midwifery, I learned so much. Learning and

being involved in [midwifery] opened my eyes to what I could do [as a midwife]. [Midwifery] was so much more than I could have thought. … Even now, you learn from older colleagues and with the newer generations [of midwives]' (Grace)

Midwives' identity ethos

The principal quality that interviewees see in midwives, and by extension themselves, is related to being knowledgeable. Other integral qualities of midwives' identity reported by the interviewees are being autonomous and reliable professionals. Honouring women's trust in them is why most midwives consider being reliable an essential characteristic of midwives:

'[When women] come back, it's like "you again" and it's like "yes". So, [women] go and tell you about all that happened to them while you didn't see them. There is a good bond that midwives must take advantage of to do everything [, to provide care] from an integral perspective' (Sam)

'[Midwives] must be intelligent. They must be very intelligent people- to have studied and to have trained a lot [to become midwives]. No, no, not everyone becomes a midwife. I mean, you must be physically and mentally prepared' (Ruth).

'I am an autonomous professional that can make their own decisions, to diagnose and predict a patient's prognosis. I am more self-sufficient in my job role and that's how I see myself' (Julia)

Midwives' responses consistently described midwifery ethos to be woman-centred. Furthermore, when interviewed, midwives describe their professional identity as a woman's companion:

'I am a professional who accompanies women throughout their life cycle. The one who is with her in everything related to sexual and reproductive health. Beyond anything else, the professional who accompanies women and who provides them with the necessary tools for her [to live their] sexual and reproductive health' (Julia)

Being able to accompany women through their life, through either continuity of care or continuity of carer, provides the most satisfaction for midwives:

'I have been working here for several years, and sometimes when meeting a patient with her toddler, I think, "I cared for her when she was pregnant [of the toddler]". That makes me feel fulfilled' (Margarita)

Midwives' scope of practice

Several interviewees suggested that before starting their degree, providing pregnancy care and delivering births was perceived to be midwives' main scope of practice. However, beyond this initial perception, all midwives, irrespective of their age, believed midwifery's current scope of practice is sexual and reproductive health and includes abortion care provision:

'[Midwives] do have to manage the abortion labour and deliver the abortion or birth -depending on how far the pregnancy is' (Sabrina)

In a more profound reflection, some midwives pondered that restricting midwifery care to pregnancy and childbirth was unwise for long-term professional sustainability:

'I believe this is the challenge we are called to face today, what today's society calls us to do… We are no longer in the time of childbirth. The birth rate is decreasing, and it will decrease even more' (Isidora)

In this category is possible to see that midwives perceive themselves as knowledgeable and reliable. Furthermore, being woman-centred is the main element of midwives' identity. In terms of their role, Chilean midwives want to accompany people, especially women, in navigating their sexual and reproductive health. Abortion care, therefore, is inherent to midwives' role as it is part of a woman's reproductive history.

Midwives' practice

This major category mutually interacts with midwives' identity and is framed into midwifery regulation (Fig. 1). It is through midwives' behaviours and practices that their identity is expressed. Likewise, these behaviours and practices inform how to be a midwife. Thus, behaviours and practices shape midwives' identity.

Midwives interviewed detailed that the major challenge of abortion provision is the emotion it evokes. Examples provided by the participants are used to illustrate how midwives' decision-making in challenging situations is informed by their professional identity. When choosing to act as a midwife, midwives' identity is reinforced in a cyclical process.

Midwives' practice and midwives' identity

There is a strong sense among interviewees that midwifery has been historically about working with and protecting life. When midwifery is perceived as naturally more inclined towards life, witnessing death becomes particularly challenging, irrespective of midwives' moral position regarding abortion and beyond abortion care:

'When one of our [patients] dies is like a thousand deaths. It is shocking, unexpected' (Sabrina)

Participants have defined midwives' identity as woman-centred. However, as mentioned above, midwives also perceived themselves as 'working towards life'. These two elements are in tension in abortion care as, on the one hand, midwives want to support women's decision-making, and on the other hand, they feel midwifery duty is towards life:

'I saw [abortion] as a mechanical process. … but it is challenging when you are in the theatre seeing it. I don't know how to explain it but when you have to live it- Even when you know it is the right thing [abortion] and it's a decision you must respect, you also feel that our work as midwives is towards life. Then, it [abortion] generates a small contradiction; it is a bit challenging [upset voice]' (Ana)

In the face of a contradiction between what midwives are required to do in practice versus their core values, midwives' identity must evolve to correct this contradiction.

Midwives' identity is depicted in core qualities they uphold as a collective, but that are interpreted individually by each midwife. When midwives report their ethos as woman-centred, this does not mean they have a univocal interpretation of the concept. For example, for some midwives, a woman-centred professional does not question women's decision-making but supports it irrespective of the way and the outcome the woman is pursuing:

'I'm not the right person to judge or have an opinion about why the mum made that decision [abortion]. For me, it is part of her options, right? I don't make further judgements about her' (Dalia)

For other midwives, a woman-centred professional can internally question women's decision-making but cannot express judgment nor change their practice:

'I do question those sorts of things [statutory rape] …Anyway, these reflections and comments from me and other colleagues do not influence our clinical practice' (Julia)

Thus, even when midwives' identity in both cases described is woman-centred, midwives' interpretations and responses to a given situation could be slightly different.

In this category the distinctive way each midwife translates being woman-centred professionals into their practice has been explored. When providing abortion care midwives enact and solidify their identity as woman-centred professionals. Therefore, the two-way interaction between midwives' identity and practice (Fig. 1) has been explained.

Midwifery regulation

This category describes how abortion regulation relates to midwives' identity and midwives' practice (Fig. 1).

Midwifery regulation and midwives' practice

The enactment of the abortion law included publishing clinical guidelines. These national guidelines, in many cases, inspired local protocols that made implementation easier and added clarity of what

was expected from each team member.

The addition of abortion care into midwives' territory of practice was welcomed by those who think the law could allow them to provide better care and better exercising a woman-centred care approach:

'Women will now be safe … now we can intervene in these situations when before women had to take [pregnancy] till the end' (Margarita)

The transition to this new territory of practice was faced with uncertainty by midwives. Although all participants stated that things are currently working well, first abortion cases were faced by midwives with a general feeling of caution and preferring not to be involved.

The desire to be helpful to women in need of abortion cannot fully materialise with the current abortion law as midwives' role does not include conducting abortions. Considering this, there is a general feeling of a missed opportunity among midwives in terms of positioning first-trimester abortion provision as a midwifery-led procedure:

'[The current abortion law] was a missed opportunity. …We should do [Manual Vacuum Aspirations]. Midwives have the knowledge and skills to handle first-trimester abortions- Just as it is done with the IUD [intrauterine device contraception provision]' (Andy)

The abortion law prompted an expansion of midwives' practice into a new territory while also being a reminder of the boundaries within midwives' role.

Midwifery regulation and midwives' identity

Formal regulation of midwifery in Chile can be seen as encouraging or restricting midwives' professional identity. As mentioned in the previous subheading, midwives agree that the current abortion law contributes to midwifery practice. However, there is variability in midwives' responses to whether the current law is enough or just a small step in the right direction:

'I think the current abortion law as the first step works, but it's not enough' (Victoria)

This variability in midwives' response to the abortion law seems to relate to how strongly they adhere to being 'woman-centred' professionals and their moral positioning regarding abortion. Midwives with more conservative views on abortion are more cautious about the idea of implementing free abortion. Ruth, who is a conscientious objector to abortion, shares her concerns about abortion becoming free access:

'If free [abortion] is enacted it is going to be a mess. People are going to terminate pregnancies for any reason' (Ruth)

Again, the variability observed in midwives' interpretation of being 'woman-centred' in abortion care provision can be seen as an expression of the multiplicity of identities within each person. Furthermore, this variability suggests there is always room for individuality in interpreting midwives' identity definition as described earlier in the category relating to midwives' identity.

Our personal values may lead us to think and act differently. As a midwife, that variability must still represent the core values that inform midwifery as a discipline. However, participants shared that they feel a lack of role models and midwifery leadership to follow:

'This position [chief of midwifery] would make no difference, even if they wanted to make one' (Andy)

Beyond national laws and statutes regulating midwifery practice, the Colleges of Midwives in Chile have little room to shape the definition and practice of midwifery in the country. This is consistent with participants' perceptions of midwifery being underrepresented in public spheres. More concerningly, Chilean midwives' code of conduct and ethical tuition is no longer a responsibility safeguarded by the College of Midwives or any other similar organisation:

'…Since the 80 s, professional associations lost ethical tuition and their regulatory role over professions. So, the only person who could take away someone's licence is a court [of justice]. …[T]oday, not many professionals are registered in Colleges. Thus, many professionals are basically in no man's land' (Alicia)

Midwifery identity sets its basis when training at university to become a midwife. However, there is a lack of direction from the College of Midwives or an equivalent authority within midwifery that safeguards what must be taught in terms of professional identity in midwifery degrees:

'There has been no national conference or seminar where midwives who know about curriculum discuss a unified midwives' national curriculum. There hasn't been a national discussion about it [midwives' curriculum/competencies], and I think it is necessary' (Elsa)

In this category, the impact of the lack of role models to guide midwifery development in Chile has been described. Also, the interaction between midwifery regulation and midwives' identity has shown that midwives as a collective and individuals can decide whether to be compliant or re-interpret regulation. The enactment of the abortion law is a good example of how regulation has pushed midwives' practice and, by that, shows a nuanced interpretation of being woman-centred.

Discussion

This study highlights that the inclusion of induced abortion care in Chile has created tension in two aspects of midwives' identity. While Chilean midwives see themselves as 'woman-centred' professionals, they also acknowledge their role is towards 'protecting life'. This tension within their identity generates feelings of contradiction in Chilean midwives, which resonates with studies on midwives and abortion care provision elsewhere (Garel et al., 2007; Mizuno, 2011; Zolala et al., 2019). Ramsayer and Fleming (2020) suggest that part of the tension between abortion and midwifery care could be explained by midwives' traditional role of care provision from conception to the postnatal period. Midwives' traditional role is challenged by abortion care as it requires terminating a pregnancy (Ramsayer and Fleming, 2020). Other studies have reported that midwives feel emotionally challenged by abortion care provision (Carvajal et al., 2022). The added complexity to this feeling, as this study has shown, is that it even extends to midwives who are in favour of abortion. This finding supports Ramsayer and Fleming's (2020) suggestion that, in abortion care, midwives' identity and not just personal values are being challenged. However, it is still unclear if midwives' identity tension is exclusively related to abortion care provision or if its origin could be traced to death-related care (Becker et al., 2023; Dartey et al., 2019; Stabnick et al., 2022). To determine the extent to which midwives' traditional role is to protect life, the concept of death within midwifery care should be explored further.

Research has shown that healthcare professionals use discretion when implementing a policy (Cheraghi-Sohi and Calnan, 2013; Harrits and Møller, 2014; Hoyle, 2014). Furthermore, during resource scarcity, discretion could reproduce inequality (Atinga et al., 2018; Charman and Williams, 2022; Nunes and Lotta, 2019). Discretion refers to making a judgement on a possible course of action either from a predefined set of options or when there is no clear option on how to proceed (Molander et al., 2012). When implementing a policy using their discretion, healthcare practitioners can navigate guidelines and protocols to make them match their values and expectations (Heymann et al., 2023; O'Neill, 2019). In this study, midwives did not report suboptimal provision of abortion care despite how challenged they felt by the topic. However, the absence of information in this matter does not prevent suboptimal abortion care provision. Midwives in this study describe a tension in their identity in abortion care. This tension should be carefully explored as it could negatively affect the policy implementation process and midwives' satisfaction with their role (Aniteye et al., 2016; Cameron, 2011; Feijen-de Jong et al., 2022). As some aspects of Chilean midwives' identity are currently in tension, as this study has shown, it becomes relevant to reflect and agree on a code of conduct that provides guidance for midwives on how to address abortion and other controversial topics within midwifery (Cowin et al., 2019). Furthermore, details on interpreting the code of conduct clauses (Snelling, 2017) could also help set common standards for midwives' professional behaviour in

controversial situations.

The model in this study helps to understand that the new abortion law echoes further than expected. When midwives practice abortion care they constantly negotiate their position towards abortion. Likewise, midwives' understanding and interpretation of being woman-centred is also negotiated. 'Navigating a maze' wants to portray that midwives exist and practice within a confined space with rules and multiple paths. There is no one correct path or definitive solution. It will depend on midwives' decisions which parts of the maze they walk, the challenges they face and what meaning they will give to their experiences. The use of the word 'navigating' in the model wants to highlight a continuous journey. Although midwives have defined goals to reach, the goal itself is not attainable but serves as an inspiration to continue the journey. In this study, the continuous journey of midwives' identity is consistent with the work of others who suggest that professional identity is in constant evolution (Fraser-Arnott, 2019; Lockyer et al., 2016). Despite its virtues in explaining the data collected in this study, 'navigating a maze' should be tested against other contexts beyond abortion care and midwifery to assess its validity in understanding the professional identity (re)construction process.

This study has both strengths and limitations. Among its strengths, the study offers a glimpse of the impact of enacting laws on controversial and morally challenging topics in the professionals who must implement them. Regarding the study limitations, considering how morally challenging abortion is in Chile, midwives from the extreme ends of abortion support spectrum could have decided to abstain from participating. However, as the study included two midwife conscientious objectors and several supporting free abortion, both views are expected to be fairly and respectfully represented. As midwives' role in induced abortion care is significantly greater in the public healthcare system (Ministerio de Salud, 2018b), the study sample focused on them to explore their experiences in care provision. Consequently, midwives within Chile's private healthcare system might not find the study findings transferrable to their setting. Likewise, considering the eligibility criteria for this study, these findings cannot be extrapolated to all Chilean midwives. Finally, qualitative studies using interviews rely heavily on participants' self-report. Therefore, these studies can be affected when participants provide socially desirable answers for fear of being judged (Bergen and Labonté, 2020; Latkin et al., 2016). Nonetheless, the research team held meetings regularly where social desirability tendencies in interviews were discussed and considered during theoretical sampling (Table 1).

Table 1
Participants characteristics.

Characteristics	N
Age	
< 30 years	3
30 – 50 years	9
> 50 years	3
Gender[a]	
Women	13
Males	2
Working experience[a]	
< 10 years	8
10 – 30 years	5
> 30 years	2
Work geographical location[a]	
Metropolitan Region	8
Other Regions	7
Religious status[a]	
Atheist	5
Agnostic	4
Catholic	4
No religion but believes in God	2
Position about abortion[a]	
Supporter	13
Conscientious objector	2
Work area[a,b]	
Obstetrical wards	6
Gynaecological wards	4
Neonatal units	2
Other[c]	6

[a] Characteristics considered during purposive sampling to achieve maximum variation of participants.
[b] Non-mutually exclusive.
[c] Not further detailed to avoid secondary disclosure. However, it includes midwives in primary care, academics, policymakers and others.

Conclusion

This study provides insight into the process of integrating induced abortion care into midwives' scope of practice in Chile. Integrating induced abortion care has created tension between woman-centredness and protecting life aspects of midwives' identity. As discretion is usually high among healthcare professionals, the current tension within midwives' identity should be carefully attended to prevent policy failure and malpractice. The study offers a model to understand how midwives' identity is in continuous reformation. Furthermore, both practice and regulation have a direct effect on midwives' self-narratives. Although the model helps explain the Chilean context within midwives and the abortion law enactment, the model's utility in other contexts, such as the inclusion of new technologies or procedures in clinical practice or law enactment/overturn, should be explored.

Statement of significance

Problem

What is already known

- An abortion law was enacted in Chile in 2017, decriminalising abortion in three circumstances.
- It is unknown how midwives will manage this aspect of their practice and care for the women.

- Midwives' values and beliefs can shape their practice.
- Abortion is a controversial topic that can challenge midwives' identity.

What this paper adds

- Two central aspects of midwives' identity come into tension with induced abortion care provision.
- Midwives' identity is shaped by practice in an interdependent process.
- This study suggests the current tension within Chilean midwives' identity must be further explored to prevent policy suboptimal implementation.

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Authors statement

The authors of this work state that they have made substantial contributions to all of the following: the conception and design of the study, or acquisition of data, or analysis and interpretation of data, drafting the article or revising it critically for important intellectual content, final approval of the version to be submitted.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2024.103938.

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